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Attorneys for Defendants UnitedHealth Group, Inc.;  
United Healthcare Services, Inc., UnitedHealthcare  
Insurance Company; OptumInsight, Inc.

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

ALMONT AMBULATORY SURGERY  
CENTER, LLC, a California limited liability  
company; BAKERSFIELD SURGERY  
INSTITUTE, LLC, a California limited  
liability company; INDEPENDENT  
MEDICAL SERVICES, INC., a California  
corporation; MODERN INSTITUTE OF  
PLASTIC SURGERY & ANTIAGING, INC.,  
a California corporation; NEW LIFE  
SURGERY CENTER, LLC, a California  
limited liability company, dba BEVERLY  
HILLS SURGERY CENTER, LLC;  
ORANGE GROVE SURGERY CENTER,  
LLC, a California limited liability company;  
SAN DIEGO AMBULATORY SURGERY  
CENTER, LLC, a California limited liability  
company; SKIN CANCER &  
RECONSTRUCTIVE SURGERY  
SPECIALISTS OF BEVERLY HILLS, INC.,  
a California corporation; VALENCIA  
AMBULATORY SURGERY CENTER,  
LLC, a California limited liability company;  
WEST HILLS SURGERY CENTER, LLC, a  
California limited liability company,

Plaintiffs,

v.

UNITEDHEALTH GROUP, INC.; UNITED  
HEALTHCARE SERVICES, INC.,  
UNITEDHEALTHCARE INSURANCE  
COMPANY; OPTUMINSIGHT, INC., and  
DOES 1 through 20,

Defendants.

Case No.

**NOTICE OF REMOVAL OF  
ACTION TO FEDERAL  
COURT**

**(28 U.S.C. §§ 1331 AND  
1441(a))**

(Superior Court of the State of  
California, County of Los  
Angeles, Central District)  
Number: BC540056)

Complaint filed: March 21, 2014

**TO THE HONORABLE JUDGES OF THE UNITED STATES DISTRICT COURT FOR THE CENTRAL DISTRICT OF CALIFORNIA AND TO PLAINTIFFS AND THEIR ATTORNEYS OF RECORD:**

Pursuant to 28 U.S.C. § 1446(a), Defendants UnitedHealth Group, Inc., United Healthcare Services, Inc., United Healthcare Insurance Company, and OptumInsight, Inc. (collectively “United”) hereby invoke this Court’s jurisdiction under the provisions of 28 U.S.C. §§ 1331 and 1441(a) and state the following grounds for removal:

1. On March 21, 2014, Plaintiffs served United with a Summons and Complaint (“Complaint”), a true and correct copy of which is attached hereto as Exhibit A. The action was filed on March 21, 2014 in the Superior Court of the State of California, County of Los Angeles, Central District, styled and captioned exactly as above, and assigned Case No. BC540056. The Complaint named four, affiliated United entities as the only defendants (along with 20 “Doe” defendants). On April 21, 2014, United filed its answer to Plaintiff’s Complaint, a true and correct copy of which is attached hereto as Exhibit B. On April 17, 2014, Plaintiffs served a copy of a Notice of Case Management Conference, a true and correct copy of which is Exhibit C hereto. No other pleadings or papers have been filed in this action. United is informed and believes that none of the (unidentified) Doe defendants have been served in this matter.

2. This Notice of Removal is timely filed as required by 28 U.S.C. § 1446(b) and Fed. R. Civ. P. 6(a) because it is filed within 30 days after service of the Summons and Complaint was first made on any of the United defendants. Where, as here, the thirtieth day falls on Sunday April 20, 2014, the thirty-day period is extended until Monday April 21, 2014. *See, e.g., Wells v. Gateways Hosp. and Mental Health Center*, 1996 WL 36184, \*1 (9th Cir. Jan. 30, 1996) (using Rule 6(a) to extend removal filing deadline from thirtieth day, which landed on a Sunday, to the following Monday); *Community Housing Partnership v. Byrd*, 2013

1 WL 6087350, \*2 (N.D.Cal.) (thirty-day period for removal fell on Saturday June  
 2 29, 2013, so period was extended until Monday July 1, 2013 by Rule 6(a));  
 3 *Hernandez v. Menlo Logistics, Inc.*, 2013 WL 5934411, \*\* 1, 18 (D.N.M.)  
 4 (collecting cases, and holding that although thirty-day deadline for removal fell on  
 5 Sunday August 26, 2012, that deadline was extended until Monday August 27,  
 6 2012 by Rule 6(a)).

7 3. All of the United Defendants, the only properly joined and served  
 8 Defendants, join in the removal of this action.

9 4. Pursuant to 28 U.S.C. § 1331, Federal District Courts have original  
 10 jurisdiction over all civil actions arising under the laws of the United States.  
 11 Pursuant to 28 U.S.C. §§ 84(c), 1331 and 1441(a), this state court action may be  
 12 removed to this Federal District Court because it is the district and division  
 13 embracing the place, the County of Los Angeles, California, where such action is  
 14 pending.

### 15 16 **FEDERAL QUESTION JURISDICTION**

17 5. The action described in Paragraph 1 above is a civil action of which  
 18 this Court has original jurisdiction under the laws of the United States, specifically  
 19 the Employee Retirement Income Security Act (“ERISA”), Title 29, United States  
 20 Code, §§ 1001 et seq., and therefore removable under 28 U.S.C. § 1441.

21 6. Ordinarily, whether an action arises under federal law depends on the  
 22 “well-pleaded complaint” rule, such that if a Complaint purports to assert only  
 23 state-law claims, it will ordinarily not be removable as arising under federal law.  
 24 *See Aetna Health Inc. v. Davila*, 542 U.S. 200, 207-08 (2004). An exception to the  
 25 well-pleaded complaint rule exists where, as here, a federal statute, such as ERISA,  
 26 wholly displaces one or more state law causes of action through “complete  
 27 preemption.” Accordingly, although Plaintiffs’ Complaint purports to assert only  
 28 five state-law causes of action, since at least some of those causes of actions are

1 entirely encompassed by § 502(a) of ERISA, 29 U.S.C. § 1132(a), the Complaint is  
 2 converted from a state law complaint into a federal claim for purposes of the well-  
 3 pleaded complaint rule. *Davila*, 542 U.S. at 207-08.

4 7. Complete preemption under § 502(a) is determined under a two-prong  
 5 test: (1) whether the plaintiff could have brought the claim under § 502(a), and (2)  
 6 whether the claim is based on duties or obligations independent of any duty under  
 7 ERISA or an ERISA plan. *Davila*, 542 U.S. at 210-13. Both prongs of this test are  
 8 satisfied here.

9 8. The Plaintiff-providers, who allege elsewhere that they have received  
 10 assignment of their patients' rights to sue for benefits under the terms of their health  
 11 plans, not only could have brought suit under § 502(a), provided that some of their  
 12 patients are covered under ERISA-governed health plans, they have already done  
 13 so. *See, e.g., Misic v. Bldg. Serv. Employees Health & Welfare Trust*, 789 F.2d  
 14 1374, 1378 (9th Cir.1986) (health care providers can sue derivatively under ERISA  
 15 and § 502(a), asserting assigned claims for benefits under the terms of ERISA  
 16 plans). The ten provider-Plaintiffs in this case have alleged in a related Complaint  
 17 that they filed in this Court on March 20, 2014 against the same United defendants,  
 18 and also against self-funded ERISA plans and their employer plan sponsors, that  
 19 they:

20 [Each] have standing to pursue these claims as assignees of  
 21 their patient's benefits. Prior to receiving treatment, every  
 22 patient of the Plaintiffs signs an "Assignments of Rights and  
 23 Benefits" form agreeing to, inter alia, assign his or her health  
 24 insurance benefits, as well as broad array of related rights, to  
 25 their providers, who are the Plaintiffs in this case.

26 Complaint, ¶ 900, in *Almont Ambulatory Surgery Center LLC ("Almont") et al. v.*  
 27 *UnitedHealth Group, Inc. et al.*, CV 14-2139 R UBKX. *See also id.*, ¶ 902  
 28 (quoting the language of the assignments given by every patient of the Plaintiffs).

1 This related, federal-court Complaint is over 1,000 pages long, so it is not  
2 submitted here as an Exhibit, but it may be accessed as Document 1 in Case 2:14-  
3 cv-02139-R-VBK, filed on March 20, 2014.

4 9. Based on the assignments received from their patients, the Plaintiff-  
5 providers in this case have brought suit against United in the related federal case  
6 for benefits due under ERISA plans, and to clarify their rights to benefits under  
7 ERISA plans. *See id.*, ¶¶ 1005-16. The Plaintiff-providers did so by alleging that  
8 they submitted claims for payment to United as a claims administrator of  
9 employee welfare benefits plans governed under ERISA (*id.*, ¶ 21), and then  
10 identifying in the body of the Complaint six examples of claims for benefits that  
11 had allegedly been wrongly denied by United under six identified ERISA-  
12 governed employee welfare benefit plans established by Time Warner Cable Inc.,  
13 Target Corporation, Apple, Inc., Danaher Corporation, AT&T Corp., and Aegis  
14 Media Americas, Inc.. *Id.*, ¶ 982. The federal-court Complaint also contains an  
15 Appendix A that purports to identify claims for benefits relating to 411 patients  
16 under specifically-identified ERISA plans.

17 10. It is also clear from the face of the state-court Complaint that claims  
18 asserted therein relate to patients who are covered by the ERISA-governed  
19 employee benefit plans identified in the related federal Complaint. In the state-  
20 court Complaint, Plaintiffs assert claims, and seek relief, regarding “all” of the  
21 claims they have submitted to United, which have been denied. This “all”  
22 necessarily includes these same Plaintiffs’ claims in the federal-court Complaint  
23 that have been denied by United under identified ERISA-governed employee  
24 benefits plans. Specifically, in the fifth cause of action (p. 42), and then again in  
25 the “Wherefore” clause (p. 43), Plaintiffs seek a declaration that:

26 Defendants are required timely re-process all claims that have  
27 been submitted by the Plaintiffs since United first began its  
28 campaign to deny payments to the Plaintiffs, and to pay those

1           claims pursuant to the terms of the Plans; \* \* \* [and]  
 2           Defendants must conduct a "full and fair review" for all claims  
 3           being re-processed, free of dishonest and surreptitious delay  
 4           and denial tactics.

5   The quoted "full and fair review" refers to ERISA, 29 U.S.C. § 1133(2), which  
 6   requires that every ERISA plan provide adequate notice of claim denials and "a  
 7   reasonable opportunity ... for a full and fair review by the appropriate named  
 8   fiduciary of the decision denying the claim." This provision, its implementing  
 9   regulation, 29 C.F.R. § 2560.503–1(h)(1), and the Plaintiffs' desire that United be  
 10   forced to conduct a "full and fair review" are referred to repeatedly in the related  
 11   federal Complaint.

12           11.   Separate from the patients identified in the related federal Complaint  
 13   and its Appendix A, United has identified seven patients that received lap band or  
 14   endoscopy services from nine of the 10 Plaintiff-providers in this case (all but  
 15   Valencia Ambulatory Surgery Center, LLC). These patients are beneficiaries or  
 16   participants under ERISA health plans established by their employers or their  
 17   spouses' employers, and their claims for benefits under these ERISA plans for these  
 18   services provided by the provider-Plaintiffs have been denied. *See* Declarations of  
 19   Vennise D. McCoy, and Jane Stalinski (including Exhibits 1-5 thereto). Five of  
 20   these patients are covered by the Walgreen Health Plan (Major Medical Expense  
 21   Plan), which is an ERISA-governed employee benefit plan established by Walgreen  
 22   Co., one of these patients is covered by the AT&T Medical Plan, which is an  
 23   ERISA-governed employee benefit plan established by AT&T Inc., and the seventh  
 24   example patient is covered by the SBC Medical and Group Life Insurance Plan –  
 25   CustomCare (the "SBC Plan"), which, after SBC's acquisition of AT&T Corp. and  
 26   re-naming itself AT&T Inc., became part of the AT&T Medical Plan Network. The  
 27   SBC Plan is an ERISA-governed employee benefit plan established by SBC and  
 28   now maintained by AT&T. *See id.* As the SPDs reflect (Stalinski Decl. Exs. 1-5)

1 Walgreen, SBC and AT&T are also employers engaged in commerce. *See* 29  
 2 U.S.C. § 1003(a) (1988).

3 12. The seventh United example patient is also a patient that has assigned  
 4 insurance and ERISA plan benefits to Plaintiffs Orange Grove Surgery Center and  
 5 Independent Medical Services, Inc. with respect to certain lap band, endoscopy or  
 6 related services, for which payment has been denied by United. *See* McCoy  
 7 Declaration ¶ 10 & Ex. I, which has been redacted to delete the name of patient 7.

8 13. In short, Plaintiffs, who now seek relief in their state-court Complaint  
 9 regarding all of their claims that have been denied by United, could have brought  
 10 suit as assignees under ERISA for the portion of their patients whose claims for  
 11 benefits are covered under ERISA plans, *i.e.* United example patients one-seven,  
 12 and the patients identified in the Federal Court Complaint and Appendix A thereto.  
 13 Indeed, the Plaintiffs have done so in the federal-court Complaint. Thus, the first  
 14 prong for removal is satisfied.

15 14. Regarding the second removal prong, the third and fifth causes of  
 16 action set forth in the state-court Complaint are plainly removable because, on their  
 17 face, (a) interpretation of the terms of ERISA plans forms an essential part of both  
 18 claims, and (b) the fifth cause of action seeks to enforce obligations imposed by  
 19 ERISA.

20 15. The fifth cause of action, on its face (¶¶ 154-55), seeks a declaration  
 21 requiring United both to conduct a “full and fair review” of all claims of the  
 22 Plaintiff-providers that have been denied and then “to pay those claims pursuant to  
 23 the terms of the Plans.” This exact relief is authorized by ERISA. A claim for  
 24 benefits under an ERISA-governed plan may only be brought under ERISA §  
 25 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B). *Davila*, 542 U.S. at 207-08. It is well  
 26 established that ERISA completely preempts state law breach of contract or  
 27 declaratory relief claims seeking recovery of benefits. *See, e.g., Pilot Life Ins. Co.*  
 28 *v. Dedeaux*, 481 U.S. 41, 41-42 (1987). The “full and fair review” requirement is

1 an ERISA requirement, and many of the plans of the Plaintiffs' patients, as  
2 reflected in the Federal Complaint, and in the McCoy and Stalinski Declarations,  
3 are ERISA plans. Thus, the fifth cause of action is not based on duties independent  
4 of those imposed by ERISA or the terms of ERISA plans, as necessary to escape  
5 complete preemption.

6 16. The third cause of action for equitable estoppel, on its face, is likewise  
7 not based on duties independent of the terms of ERISA plans. Indeed, that claim is  
8 expressly based on the terms of the plans, and would require the Court to interpret  
9 the plans and/or declare them to be ambiguous. Plaintiffs allege in paragraph 139  
10 that "[t]he language of the plans pertaining to benefits for out-of-network surgery  
11 either clearly provided that those benefits would be paid at a UCR rate, or if they  
12 did not, the terms of the plan were ambiguous." Accordingly, Plaintiffs' third and  
13 fifth causes of action are completely preempted, such that this action may be  
14 removed to this Court. *See Melamed, M.D. v. Blue Cross of California*, 2014 WL  
15 543409, \*2 (9th Cir. 2014) (complete preemption of an individual claim is  
16 sufficient for removal to be proper).

17 17. Plaintiffs' remaining causes of action, in whole or in part, are also  
18 subject to removal as arising under federal law (including the Americans with  
19 Disabilities Act) or being completely preempted by ERISA because, among other  
20 things, they require plan interpretation and/or implicate ERISA plan administration,  
21 e.g. the grant of pre-authorization under the terms of the plan, complete with letters  
22 confirming that pre-authorization is not a guarantee of payment under the terms of  
23 the plan. *See, e.g.*, Complaint ¶¶ 30, 60 and 97, incorporated into all of Plaintiffs'  
24 causes of action.

25 ///

26 ///

27 ///

28 ///

1 WHEREFORE, Defendants UnitedHealth Group, Inc., United Healthcare  
2 Services, Inc., United Healthcare Insurance Company, and OptumInsight, Inc.  
3 request that this action be brought to this Court, and that this Court exercise its  
4 jurisdiction over Plaintiffs' Complaint.

5  
6 Dated: April 21, 2014

WALRAVEN & WESTERFELD LLP

7  
8 By:

  
BRYAN WESTERFELD

9 Attorneys for Defendants UnitedHealth  
10 Group, Inc., United Healthcare Services,  
11 Inc., UnitedHealthcare Insurance  
12 Company, and OptumInsight, Inc.  
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SUM-100

# SUMMONS (CITACION JUDICIAL)

**NOTICE TO DEFENDANT:****(AVISO AL DEMANDADO):**

UNITEDHEALTH GROUP, INC.; UNITED HEALTHCARE SERVICES, INC.,  
UNITEDHEALTHCARE INSURANCE COMPANY, OPTUMINSIGHT, INC., and  
DOES 1 through 20.

**YOU ARE BEING SUED BY PLAINTIFF:****(LO ESTÁ DEMANDANDO EL DEMANDANTE):**

ALMONT AMBULATORY SURGERY CENTER, LLC. (SEE ATTACHMENT  
FOR ADDITIONAL PLAINTIFFS)

FOR COURT USE ONLY  
(SOLO PARA USO DE LA CORTE)

CONFORMED COPY  
ORIGINAL FILED  
Superior Court of California  
County Of Los Angeles

MAR 21 2014

Sherri R. Carter, Executive Officer/Clerk  
By: Amber Hayes, Deputy

**NOTICE!** You have been sued. The court may decide against you without your being heard unless you respond within 30 days. Read the information below.

You have 30 CALENDAR DAYS after this summons and legal papers are served on you to file a written response at this court and have a copy served on the plaintiff. A letter or phone call will not protect you. Your written response must be in proper legal form if you want the court to hear your case. There may be a court form that you can use for your response. You can find these court forms and more information at the California Courts Online Self-Help Center ([www.courtinfo.ca.gov/selfhelp](http://www.courtinfo.ca.gov/selfhelp)), your county law library, or the courthouse nearest you. If you cannot pay the filing fee, ask the court clerk for a fee waiver form. If you do not file your response on time, you may lose the case by default, and your wages, money, and property may be taken without further warning from the court.

There are other legal requirements. You may want to call an attorney right away. If you do not know an attorney, you may want to call an attorney referral service. If you cannot afford an attorney, you may be eligible for free legal services from a nonprofit legal services program. You can locate these nonprofit groups at the California Legal Services Web site ([www.lawhelpcalifornia.org](http://www.lawhelpcalifornia.org)), the California Courts Online Self-Help Center ([www.courtinfo.ca.gov/selfhelp](http://www.courtinfo.ca.gov/selfhelp)), or by contacting your local court or county bar association. NOTE: The court has a statutory lien for waived fees and costs on any settlement or arbitration award of \$10,000 or more in a civil case. The court's lien must be paid before the court will dismiss the case. **AVISO!** Lo han demandado. Si no responde dentro de 30 días, la corte puede decidir en su contra sin escuchar su versión. Lea la información a continuación.

Tiene 30 DÍAS DE CALENDARIO después de que le entreguen esta citación y papeles legales para presentar una respuesta por escrito en esta corte y hacer que se entregue una copia al demandante. Una carta o una llamada telefónica no lo protegen. Su respuesta por escrito tiene que estar en formato legal correcto si desea que procesen su caso en la corte. Es posible que haya un formulario que usted pueda usar para su respuesta. Puede encontrar estos formularios de la corte y más información en el Centro de Ayuda de las Cortes de California ([www.sucorte.ca.gov](http://www.sucorte.ca.gov)), en la biblioteca de leyes de su condado o en la corte que le quede más cerca. Si no puede pagar la cuota de presentación, pida al secretario de la corte que le dé un formulario de exención de pago de cuotas. Si no presente su respuesta a tiempo, puede perder el caso por incumplimiento y la corte le podrá quitar su sueldo, dinero y bienes sin más advertencia.

Hay otros requisitos legales. Es recomendable que llame a un abogado inmediatamente. Si no conoce a un abogado, puede llamar a un servicio de remisión a abogados. Si no puede pagar a un abogado, es posible que cumpla con los requisitos para obtener servicios legales gratuitos de un programa de servicios legales sin fines de lucro. Puede encontrar estos grupos sin fines de lucro en el sitio web de California Legal Services ([www.lawhelpcalifornia.org](http://www.lawhelpcalifornia.org)), en el Centro de Ayuda de las Cortes de California ([www.sucorte.ca.gov](http://www.sucorte.ca.gov)) o poniéndose en contacto con la corte o el colegio de abogados locales. **AVISO:** Por ley, la corte tiene derecho a reclamar las cuotas y los costos exentos por imponer un gravamen sobre cualquier recuperación de \$10,000 o más de valor recibida mediante un acuerdo o una concesión de arbitraje en un caso de derecho civil. Tiene que pagar el gravamen de la corte antes de que la corte pueda desochar el caso.

The name and address of the court is:

(El nombre y dirección de la corte es):

Superior Court of California - Los Angeles  
111 N. Hill Street  
Los Angeles, CA 90012

CASE NUMBER  
(Número del Caso)

BC540056

The name, address, and telephone number of plaintiff's attorney, or plaintiff without an attorney, is:

(El nombre, la dirección y el número de teléfono del abogado del demandante, o del demandante que no tiene abogado, es):

Daron L. Tooch (SBN 137269)  
Hooper, Lundy & Bookman, P.C.  
1875 Century Park East, Suite 1600, Los Angeles, CA 90067  
Phone (310) 551-8111 - Fax (310) 551-8181

DATE:

(Fecha)

SHERRI R. CARTER Clerk, by  
(Secretario)

Amber Hayes

Deputy  
(Adjunto)

(For proof of service of this summons, use Proof of Service of Summons (form POS-010).)

(Para prueba de entrega de esta citación use el formulario Proof of Service of Summons, (POS-010)).

(SEAL)

MAR 21 2014

**NOTICE TO THE PERSON SERVED: You are served**

1. ☐ as an individual defendant.

2. ☐ as the person sued under the fictitious name of (specify):

3. ☒ on behalf of (specify): **United Health Group, INC.**

under: ☒ CCP 416.10 (corporation)

☐ CCP 416.60 (minor)

☐ CCP 416.20 (defunct corporation)

☐ CCP 416.70 (conservatee)

☐ CCP 416.40 (association or partnership)

☐ CCP 416.90 (authorized person)

☐ other (specify):

4. ☐ by personal delivery on (date):

SUM-100

# SUMMONS (CITACION JUDICIAL)

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FOR ADDITIONAL PLAINTIFFS)

FOR COURT USE ONLY  
(SOLO PARA USO DE LA CORTE)

CONFORMED COPY  
ORIGINAL FILED  
Superior Court Of California  
County Of Los Angeles

MAR 21 2014

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By: Amber Hayes, Deputy

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The name and address of the court is:

(El nombre y dirección de la corte es):  
Superior Court of California -Los Angeles  
111 N. Hill Street  
Los Angeles, CA 90012

CASE NUMBER:  
(Número del Caso):

8C540056

The name, address, and telephone number of plaintiff's attorney, or plaintiff without an attorney, is:

(El nombre, la dirección y el número de teléfono del abogado del demandante, o del demandante que no tiene abogado, es):

Daron L. Tooch (SBN 137269)  
Hooper, Lundy & Bookman, P.C.  
1875 Century Park East, Suite 1600, Los Angeles, CA 90067  
Phone (310) 551-8111 - Fax (310) 551-8181

DATE:

(Fecha)

SHERRI R. CARTER Clerk, by  
(Secretario)

Amber Hayes

Deputy  
(Adjunto)

(For proof of service of this summons, use Proof of Service of Summons (form POS-010).)

(Para prueba de entrega de esta citación use el formulario Proof of Service of Summons, (POS-010)).

(SEAL)

MAR 21 2014

**NOTICE TO THE PERSON SERVED: You are served**

1. ☐ as an individual defendant.
2. ☐ as the person sued under the fictitious name of (specify):
3. ☐ on behalf of (specify):  
under: ☐ CCP 416.10 (corporation) ☐ CCP 416.60 (minor)  
☐ CCP 416.20 (defunct corporation) ☐ CCP 416.70 (conservatee)  
☐ CCP 416.40 (association or partnership) ☐ CCP 416.90 (authorized person)  
☐ other (specify):
4. ☐ by personal delivery on (date):

SUM-200(A)

SHORT TITLE: ALMONT AMBULATORY v. UNITED HEALTHCARE, et al.	CASE NUMBER:
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## INSTRUCTIONS FOR USE

- This form may be used as an attachment to any summons if space does not permit the listing of all parties on the summons.  
 → If this attachment is used, insert the following statement in the plaintiff or defendant box on the summons: "Additional Parties Attachment form is attached."

List additional parties (Check only one box. Use a separate page for each type of party.):

☒ Plaintiff    ☐ Defendant    ☐ Cross-Complainant    ☐ Cross-Defendant

BAKERSFIELD SURGERY INSTITUTE, LLC, a California limited liability company;  
 INDEPENDENT MEDICAL SERVICES, INC., a California corporation;  
 MODERN INSTITUTE OF PLASTIC SURGERY & ANTIAGING, INC., a California corporation;  
 NEW LIFE SURGERY CENTER, LLC, a California limited liability company, dba BEVERLY HILLS SURGERY CENTER;  
 ORANGE GROVE SURGERY CENTER, LLC, a California limited liability company;  
 SAN DIEGO AMBULATORY SURGERY CENTER, LLC, a California limited liability company;  
 SKIN CANCER & RECONSTRUCTIVE SURGERY SPECIALISTS OF BEVERLY HILLS, INC., a California corporation;  
 VALENCIA AMBULATORY SURGERY CENTER, LLC, a California limited liability company;  
 WEST HILLS SURGERY CENTER, LLC, a California limited liability company

Page 2 of 2

Page 1 of 1

**SUPERIOR COURT OF CALIFORNIA, COUNTY OF LOS ANGELES**  
**NOTICE OF CASE ASSIGNMENT - UNLIMITED CIVIL CASE (NON-CLASS ACTION)**

Case Number \_\_\_\_\_

80540056

**THIS FORM IS TO BE SERVED WITH THE SUMMONS AND COMPLAINT**

Your case is assigned for all purposes to the judicial officer indicated below. There is additional information on the reverse side of this form.

ASSIGNED JUDGE	DEPT	ROOM	ASSIGNED JUDGE	DEPT	ROOM
Hon. Daniel Buckley	1	534	Hon. Malcolm H. Mackey	55	515
Hon. Barbara A. Meiers	12	636	Hon. Michael Johnson	56	514
Hon. Terry A. Green	14	300	Hon. Rolf M. Treu	58	516
Hon. Richard Fruin	15	307	Hon. Michael L. Stern	62	600
Hon. Rita Miller	16	306	Hon. Mark Mooney	68	617
Hon. Richard E. Rico	17	309	Hon. William F. Fahey	69	621
Hon. Kevin C. Brazile	20	310	Hon. Soussan G. Bruguera	71	729
Hon. Robert L. Hess	24	314	Hon. Ruth Ann Kwan	72	731
Hon. Yvette M. Palazuelos	28	318	Hon. Rafael Ongkeko	73	733
Hon. Barbara Scheper	30	400	Hon. Teresa Sanchez-Gordon	74	735
Hon. Mary H. Strobel	32	406			
Hon. Michael P. Linfield	34	408			
Hon. Gregory Alarcon	36	410	<b>Hon. Emilie H. Elias</b>	<b>324</b>	<b>CCW</b>
Hon. Maureen Duffy-Lewis	38	412	<b>Hon. Elihu M. Berle*</b>	<b>323</b>	<b>CCW</b>
Hon. Michelle R. Rosenblatt	40	414			
Hon. Holly E. Kendig	42	416			
Hon. Mel Red Recana	45	529			
Hon. Frederick C. Shaller	46	500			
✓ Hon. Debra Katz Weintraub	47	507			
Hon. Elizabeth Allen White	48	506			
Hon. Deirdre Hill	49	509			
Hon. John L. Segal	50	508			
Hon. Mitchell L. Beckloff	51	511			
Hon. Susan Bryant-Deason	52	510			
Hon. Steven J. Kleinfeld	53	513			
Hon. Ernest M. Hiroshige	54	512	OTHER		

**\*Complex**

All cases designated as complex (other than class actions) are initially assigned to Judge Elihu M. Berle in Department 323 of the Central Civil West Courthouse (600 S. Commonwealth Ave., Los Angeles 90005). This assignment is for the purpose of assessing whether or not the case is complex within the meaning of California Rules of Court, rule 3.400. Depending on the outcome of that assessment, the case may be reassigned to one of the judges of the Complex Litigation Program or reassigned randomly to a court in the Central District.

Given to the Plaintiff/Cross-Complainant/Attorney of Record on \_\_\_\_\_ **SHERRI R. CARTER**, Executive Officer/Clerk  
 By \_\_\_\_\_, Deputy Clerk

**INSTRUCTIONS FOR HANDLING UNLIMITED CIVIL CASES**

The following critical provisions of the Chapter Three Rules, as applicable in the Central District, are summarized for your assistance.

**APPLICATION**

The Chapter Three Rules were effective January 1, 1994. They apply to all general civil cases.

**PRIORITY OVER OTHER RULES**

The Chapter Three Rules shall have priority over all other Local Rules to the extent the others are inconsistent.

**CHALLENGE TO ASSIGNED JUDGE**

A challenge under Code of Civil Procedure section 170.6 must be made within 15 days after notice of assignment for all purposes to a judge, or if a party has not yet appeared, within 15 days of the first appearance.

**TIME STANDARDS**

Cases assigned to the Individual Calendaring Court will be subject to processing under the following time standards:

**COMPLAINTS:** All complaints shall be served within 60 days of filing and proof of service shall be filed within 90 days of filing.

**CROSS-COMPLAINTS:** Without leave of court first being obtained, no cross-complaint may be filed by any party after their answer is filed. Cross-complaints shall be served within 30 days of the filing date and a proof of service filed within 60 days of the filing date.

A Status Conference will be scheduled by the assigned Independent Calendar Judge no later than 270 days after the filing of the complaint. Counsel must be fully prepared to discuss the following issues: alternative dispute resolution, bifurcation, settlement, trial date, and expert witnesses.

**FINAL STATUS CONFERENCE**

The Court will require the parties at a status conference not more than 10 days before the trial to have timely filed and served all motions in limine, bifurcation motions, statements of major evidentiary issues, dispositive motions, requested jury instructions, and special jury instructions and special jury verdicts. These matters may be heard and resolved at this conference. At least 5 days before this conference, counsel must also have exchanged lists of exhibits and witnesses and have submitted to the court a brief statement of the case to be read to the jury panel as required by Chapter Eight of the Los Angeles Superior Court Rules.

**SANCTIONS**

The court will impose appropriate sanctions for the failure or refusal to comply with Chapter Three Rules, orders made by the Court, and time standards or deadlines established by the Court or by the Chapter Three Rules. Such sanctions may be on a party or if appropriate on counsel for the party.

**This is not a complete delineation of the Chapter Three Rules, and adherence only to the above provisions is therefore not a guarantee against the imposition of sanctions under Trial Court Delay Reduction. Careful reading and compliance with the actual Chapter Rules is absolutely imperative.**

CM-010

ATTORNEY OR PARTY WITHOUT ATTORNEY (Name, State Bar number, and address): DARON L. TOOCH (SBN 137269) HOOPER, LUNDY & BOOKMAN 1875 Century Park East, Suite 1600 Los Angeles, CA 90067 TELEPHONE NO.: (310) 515-8111 FAX NO.: (310) 515-8181 ATTORNEY FOR (Name): Plaintiffs		FOR COURT USE ONLY  <b>CONFORMED COPY</b> <b>ORIGINAL FILED</b> Superior Court Of California County Of Los Angeles  MAR 21 2014  Sherri R. Carter, Executive Officer/Clerk By: Amber Hayes, Deputy
SUPERIOR COURT OF CALIFORNIA, COUNTY OF LOS ANGELES STREET ADDRESS: 111 N. Hill Street MAILING ADDRESS: CITY AND ZIP CODE: Los Angeles, CA 90012 BRANCH NAME: Central District		
CASE NAME: Almont Ambulatory Surgery Center, et al. v. UnitedHealth Group, Inc., et al.		
<b>CIVIL CASE COVER SHEET</b> <input checked="" type="checkbox"/> Unlimited (Amount demanded exceeds \$25,000) <input type="checkbox"/> Limited (Amount demanded is \$25,000 or less)	Complex Case Designation <input type="checkbox"/> Counter <input type="checkbox"/> Joinder Filed with first appearance by defendant (Cal. Rules of Court, rule 3.402)	
		CASE NUMBER: <b>BC540056</b> JUDGE: DEPT:

Items 1-6 below must be completed (see instructions on page 2).

1. Check one box below for the case type that best describes this case:

<b>Auto Tort</b> <input type="checkbox"/> Auto (22) <input type="checkbox"/> Uninsured motorist (46) <b>Other PI/PD/WD (Personal Injury/Property Damage/Wrongful Death) Tort</b> <input type="checkbox"/> Asbestos (04) <input type="checkbox"/> Product liability (24) <input type="checkbox"/> Medical malpractice (45) <input type="checkbox"/> Other PI/PD/WD (23) <b>Non-PI/PD/WD (Other) Tort</b> <input checked="" type="checkbox"/> Business tort/unfair business practice (07) <input type="checkbox"/> Civil rights (08) <input type="checkbox"/> Defamation (13) <input type="checkbox"/> Fraud (16) <input type="checkbox"/> Intellectual property (19) <input type="checkbox"/> Professional negligence (25) <input type="checkbox"/> Other non-PI/PD/WD tort (35) <b>Employment</b> <input type="checkbox"/> Wrongful termination (36) <input type="checkbox"/> Other employment (15)	<b>Contract</b> <input type="checkbox"/> Breach of contract/warranty (06) <input type="checkbox"/> Rule 3.740 collections (09) <input type="checkbox"/> Other collections (09) <input type="checkbox"/> Insurance coverage (18) <input type="checkbox"/> Other contract (37) <b>Real Property</b> <input type="checkbox"/> Eminent domain/inverse condemnation (14) <input type="checkbox"/> Wrongful eviction (33) <input type="checkbox"/> Other real property (26) <b>Unlawful Detainer</b> <input type="checkbox"/> Commercial (31) <input type="checkbox"/> Residential (32) <input type="checkbox"/> Drugs (38) <b>Judicial Review</b> <input type="checkbox"/> Asset forfeiture (05) <input type="checkbox"/> Petition re: arbitration award (11) <input type="checkbox"/> Writ of mandate (02) <input type="checkbox"/> Other judicial review (39)	<b>Provisionally Complex Civil Litigation</b> (Cal. Rules of Court, rules 3.400-3.403) <input type="checkbox"/> Antitrust/Trade regulation (03) <input type="checkbox"/> Construction defect (10) <input type="checkbox"/> Mass tort (40) <input type="checkbox"/> Securities litigation (28) <input type="checkbox"/> Environmental/Toxic tort (30) <input type="checkbox"/> Insurance coverage claims arising from the above listed provisionally complex case types (41) <b>Enforcement of Judgment</b> <input type="checkbox"/> Enforcement of judgment (20) <b>Miscellaneous Civil Complaint</b> <input type="checkbox"/> RICO (27) <input type="checkbox"/> Other complaint (not specified above) (42) <b>Miscellaneous Civil Petition</b> <input type="checkbox"/> Partnership and corporate governance (21) <input type="checkbox"/> Other petition (not specified above) (43)
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2. This case ☐ is ☒ is not complex under rule 3.400 of the California Rules of Court. If the case is complex, mark the factors requiring exceptional judicial management:
- a. ☐ Large number of separately represented parties d. ☐ Large number of witnesses
- b. ☐ Extensive motion practice raising difficult or novel issues that will be time-consuming to resolve e. ☐ Coordination with related actions pending in one or more courts in other counties, states, or countries, or in a federal court
- c. ☐ Substantial amount of documentary evidence f. ☐ Substantial postjudgment judicial supervision
3. Remedies sought (check all that apply): a. ☒ monetary b. ☒ nonmonetary; declaratory or injunctive relief c. ☐ punitive
4. Number of causes of action (specify): 5
5. This case ☐ is ☒ is not a class action suit.
6. If there are any known related cases, file and serve a notice of related case. (You may use form CM-015.)

Date: March 21, 2014

DARON TOOCH

(TYPE OR PRINT NAME)

(SIGNATURE OF PARTY OR ATTORNEY FOR PARTY)

## NOTICE

- Plaintiff must file this cover sheet with the first paper filed in the action or proceeding (except small claims cases or cases filed under the Probate Code, Family Code, or Welfare and Institutions Code). (Cal. Rules of Court, rule 3.220.) Failure to file may result in sanctions.
- File this cover sheet in addition to any cover sheet required by local court rule.
- If this case is complex under rule 3.400 et seq. of the California Rules of Court, you must serve a copy of this cover sheet on all other parties to the action or proceeding.
- Unless this is a collections case under rule 3.740 or a complex case, this cover sheet will be used for statistical purposes only.

Page 1 of 2

 Form Adopted for Mandatory Use  
 Judicial Council of California  
 CM-010 (Rev. July 1, 2007)

## CIVIL CASE COVER SHEET

 Cal. Rules of Court, rules 2.30, 3.220, 3.400-3.403, 3.740;  
 Cal. Standards of Judicial Administration, std. 3.10  
 www.courtinfo.ca.gov

COPY

BY FAX

## INSTRUCTIONS ON HOW TO COMPLETE THE COVER SHEET

**To Plaintiffs and Others Filing First Papers.** If you are filing a first paper (for example, a complaint) in a civil case, you must complete and file, along with your first paper, the *Civil Case Cover Sheet* contained on page 1. This information will be used to compile statistics about the types and numbers of cases filed. You must complete items 1 through 6 on the sheet. In item 1, you must check **one** box for the case type that best describes the case. If the case fits both a general and a more specific type of case listed in item 1, check the more specific one. If the case has multiple causes of action, check the box that best indicates the primary cause of action. To assist you in completing the sheet, examples of the cases that belong under each case type in item 1 are provided below. A cover sheet must be filed only with your initial paper. Failure to file a cover sheet with the first paper filed in a civil case may subject a party, its counsel, or both to sanctions under rules 2.30 and 3.220 of the California Rules of Court.

**To Parties in Rule 3.740 Collections Cases.** A "collections case" under rule 3.740 is defined as an action for recovery of money owed in a sum stated to be certain that is not more than \$25,000, exclusive of interest and attorney's fees, arising from a transaction in which property, services, or money was acquired on credit. A collections case does not include an action seeking the following: (1) tort damages, (2) punitive damages, (3) recovery of real property, (4) recovery of personal property, or (5) a prejudgment writ of attachment. The identification of a case as a rule 3.740 collections case on this form means that it will be exempt from the general time-for-service requirements and case management rules, unless a defendant files a responsive pleading. A rule 3.740 collections case will be subject to the requirements for service and obtaining a judgment in rule 3.740.

**To Parties in Complex Cases.** In complex cases only, parties must also use the *Civil Case Cover Sheet* to designate whether the case is complex. If a plaintiff believes the case is complex under rule 3.400 of the California Rules of Court, this must be indicated by completing the appropriate boxes in items 1 and 2. If a plaintiff designates a case as complex, the cover sheet must be served with the complaint on all parties to the action. A defendant may file and serve no later than the time of its first appearance a joinder in the plaintiff's designation, a counter-designation that the case is not complex, or, if the plaintiff has made no designation, a designation that the case is complex.

## CASE TYPES AND EXAMPLES

## Auto Tort

Auto (22)—Personal Injury/Property Damage/Wrongful Death  
Uninsured Motorist (46) (if the case involves an uninsured motorist claim subject to arbitration, check this item instead of Auto)

## Other PI/PD/WD (Personal Injury/Property Damage/Wrongful Death) Tort

Asbestos (04)  
Asbestos Property Damage  
Asbestos Personal Injury/Wrongful Death  
Product Liability (not asbestos or toxic/environmental) (24)  
Medical Malpractice (45)  
Medical Malpractice—Physicians & Surgeons  
Other Professional Health Care Malpractice  
Other PI/PD/WD (23)  
Premises Liability (e.g., slip and fall)  
Intentional Bodily Injury/PD/WD (e.g., assault, vandalism)  
Intentional Infliction of Emotional Distress  
Negligent Infliction of Emotional Distress  
Other PI/PD/WD

## Non-PI/PD/WD (Other) Tort

Business Tort/Unfair Business Practice (07)  
Civil Rights (e.g., discrimination, false arrest) (not civil harassment) (08)  
Defamation (e.g., slander, libel) (13)  
Fraud (16)  
Intellectual Property (19)  
Professional Negligence (25)  
Legal Malpractice  
Other Professional Malpractice (not medical or legal)  
Other Non-PI/PD/WD Tort (35)

## Employment

Wrongful Termination (36) Other Employment (15)

## Contract

Breach of Contract/Warranty (06)  
Breach of Rental/Lease  
Contract (not unlawful detainer or wrongful eviction)  
Contract/Warranty Breach—Seller Plaintiff (not fraud or negligence)  
Negligent Breach of Contract/Warranty  
Other Breach of Contract/Warranty  
Collections (e.g., money owed, open book accounts) (09)  
Collection Case—Seller Plaintiff  
Other Promissory Note/Collections Case  
Insurance Coverage (not provisionally complex) (18)  
Auto Subrogation  
Other Coverage  
Other Contract (37)  
Contractual Fraud  
Other Contract Dispute

## Real Property

Eminent Domain/Inverse Condemnation (14)  
Wrongful Eviction (33)  
Other Real Property (e.g., quiet title) (26)  
Writ of Possession of Real Property  
Mortgage Foreclosure  
Quiet Title  
Other Real Property (not eminent domain, landlord/tenant, or foreclosure)

## Unlawful Detainer

Commercial (31)  
Residential (32)  
Drugs (38) (if the case involves illegal drugs, check this item; otherwise, report as Commercial or Residential)

## Judicial Review

Asset Forfeiture (05)  
Petition Re: Arbitration Award (11)  
Writ of Mandate (02)  
Writ—Administrative Mandamus  
Writ—Mandamus on Limited Court Case Matter  
Writ—Other Limited Court Case Review  
Other Judicial Review (39)  
Review of Health Officer Order  
Notice of Appeal—Labor Commissioner Appeals

## Provisionally Complex Civil Litigation (Cal. Rules of Court Rules 3.400–3.403)

Antitrust/Trade Regulation (03)  
Construction Defect (10)  
Claims Involving Mass Tort (40)  
Securities Litigation (28)  
Environmental/Toxic Tort (30)  
Insurance Coverage Claims (arising from provisionally complex case type listed above) (41)

## Enforcement of Judgment

Enforcement of Judgment (20)  
Abstract of Judgment (Out of County)  
Confession of Judgment (non-domestic relations)  
Sister State Judgment  
Administrative Agency Award (not unpaid taxes)  
Petition/Certification of Entry of Judgment on Unpaid Taxes  
Other Enforcement of Judgment Case

## Miscellaneous Civil Complaint

RICO (27)  
Other Complaint (not specified above) (42)  
Declaratory Relief Only  
Injunctive Relief Only (non-harassment)  
Mechanics Lien  
Other Commercial Complaint Case (non-tort/non-complex)  
Other Civil Complaint (non-tort/non-complex)

## Miscellaneous Civil Petition

Partnership and Corporate Governance (21)  
Other Petition (not specified above) (43)  
Civil Harassment  
Workplace Violence  
Elder/Dependent Adult Abuse  
Election Contest  
Petition for Name Change  
Petition for Relief From Late Claim  
Other Civil Petition

SHORT TITLE:  
ALMONT AMBULATORY v. UNITEDHEALTH GROUP, et al.

CASE NUMBER

**CIVIL CASE COVER SHEET ADDENDUM AND  
STATEMENT OF LOCATION  
(CERTIFICATE OF GROUNDS FOR ASSIGNMENT TO COURTHOUSE LOCATION)**

This form is required pursuant to Local Rule 2.0 in all new civil case filings in the Los Angeles Superior Court.

**Item I.** Check the types of hearing and fill in the estimated length of hearing expected for this case:

JURY TRIAL? ☒ YES CLASS ACTION? ☐ YES LIMITED CASE? ☐ YES TIME ESTIMATED FOR TRIAL 20 ☐ HOURS/ ☒ DAYS

**Item II.** Indicate the correct district and courthouse location (4 steps – If you checked "Limited Case", skip to Item III, Pg. 4):

**Step 1:** After first completing the Civil Case Cover Sheet form, find the main Civil Case Cover Sheet heading for your case in the left margin below, and, to the right in Column **A**, the Civil Case Cover Sheet case type you selected.

**Step 2:** Check one Superior Court type of action in Column **B** below which best describes the nature of this case.

**Step 3:** In Column **C**, circle the reason for the court location choice that applies to the type of action you have checked. For any exception to the court location, see Local Rule 2.0.

**Applicable Reasons for Choosing Courthouse Location (see Column C below)**

1. Class actions must be filed in the Stanley Mosk Courthouse, central district.
2. May be filed in central (other county, or no bodily injury/property damage).
3. Location where cause of action arose.
4. Location where bodily injury, death or damage occurred.
5. Location where performance required or defendant resides.
6. Location of property or permanently garaged vehicle.
7. Location where petitioner resides.
8. Location wherein defendant/respondent functions wholly.
9. Location where one or more of the parties reside.
10. Location of Labor Commissioner Office

**Step 4:** Fill in the information requested on page 4 in Item III; complete Item IV. Sign the declaration.

	<b>A</b> Civil Case Cover Sheet Category No.	<b>B</b> Type of Action (Check only one)	<b>C</b> Applicable Reasons (See Step 3 Above)
<b>Auto Tort</b>	Auto (22)	<input type="checkbox"/> A7100 Motor Vehicle - Personal Injury/Property Damage/Wrongful Death	1., 2., 4.
	Uninsured Motorist (46)	<input type="checkbox"/> A7110 Personal Injury/Property Damage/Wrongful Death – Uninsured Motorist	1., 2., 4.
<b>Other Personal Injury/Property Damage/Wrongful Death Tort</b>	Asbestos (04)	<input type="checkbox"/> A6070 Asbestos Property Damage <input type="checkbox"/> A7221 Asbestos - Personal Injury/Wrongful Death	2. 2.
	Product Liability (24)	<input type="checkbox"/> A7260 Product Liability (not asbestos or toxic/environmental)	1., 2., 3., 4., 8.
	Medical Malpractice (45)	<input type="checkbox"/> A7210 Medical Malpractice - Physicians & Surgeons <input type="checkbox"/> A7240 Other Professional Health Care Malpractice	1., 4. 1., 4.
	Other Personal Injury Property Damage Wrongful Death (23)	<input type="checkbox"/> A7250 Premises Liability (e.g., slip and fall)	1., 4.
		<input type="checkbox"/> A7230 Intentional Bodily Injury/Property Damage/Wrongful Death (e.g., assault, vandalism, etc.) <input type="checkbox"/> A7270 Intentional Infliction of Emotional Distress <input type="checkbox"/> A7220 Other Personal Injury/Property Damage/Wrongful Death	1., 4. 1., 3. 1., 4.

LACIV 109 (Rev. 03/11)

LASC Approved 03-04

**CIVIL CASE COVER SHEET ADDENDUM  
AND STATEMENT OF LOCATION**

Local Rule 2.0

Page 1 of 4

American LegalNet, Inc.  
www.PennWorkFlow.com

SHORT TITLE:  
ALMONT AMBULATORY v. UNITEDHEALTH GROUP, et al.

CASE NUMBER

	A Civil Case Cover Sheet Category No.	B Type of Action (Check only one)	C Applicable Reasons (See Step 3 Above)	
Non-Personal Injury/Property Damage/ Wrongful Death Tort	Business Tort (07)	<input checked="" type="checkbox"/> A6029 Other Commercial/Business Tort (not fraud/breach of contract)	1, 3	
	Civil Rights (08)	<input type="checkbox"/> A6005 Civil Rights/Discrimination	1., 2., 3.	
	Defamation (13)	<input type="checkbox"/> A6010 Defamation (slander/libel)	1., 2., 3.	
	Fraud (16)	<input type="checkbox"/> A6013 Fraud (no contract)	1., 2., 3.	
	Professional Negligence (25)	<input type="checkbox"/> A6017 Legal Malpractice <input type="checkbox"/> A6050 Other Professional Malpractice (not medical or legal)	1., 2., 3. 1., 2., 3.	
	Other (35)	<input type="checkbox"/> A6025 Other Non-Personal Injury/Property Damage tort	2., 3.	
Employment	Wrongful Termination (36)	<input type="checkbox"/> A6037 Wrongful Termination	1., 2., 3.	
	Other Employment (15)	<input type="checkbox"/> A6024 Other Employment Complaint Case <input type="checkbox"/> A6109 Labor Commissioner Appeals	1., 2., 3. 10.	
Contract	Breach of Contract/ Warranty (06) (not insurance)	<input type="checkbox"/> A6004 Breach of Rental/Lease Contract (not unlawful detainer or wrongful eviction) <input type="checkbox"/> A6008 Contract/Warranty Breach -Seller Plaintiff (no fraud/negligence) <input type="checkbox"/> A6019 Negligent Breach of Contract/Warranty (no fraud) <input type="checkbox"/> A6028 Other Breach of Contract/Warranty (not fraud or negligence)	2., 5. 2., 5. 1., 2., 5. 1., 2., 5.	
	Collections (09)	<input type="checkbox"/> A6002 Collections Case-Seller Plaintiff <input type="checkbox"/> A6012 Other Promissory Note/Collections Case	2., 5., 6. 2., 5.	
	Insurance Coverage (18)	<input type="checkbox"/> A6015 Insurance Coverage (not complex)	1., 2., 5., 8.	
	Other Contract (37)	<input type="checkbox"/> A6009 Contractual Fraud <input type="checkbox"/> A6031 Tortious Interference <input type="checkbox"/> A6027 Other Contract Dispute(not breach/insurance/fraud/negligence)	1., 2., 3., 5. 1., 2., 3., 5. 1., 2., 3., 8.	
		Eminent Domain/Inverse Condemnation (14)	<input type="checkbox"/> A7300 Eminent Domain/Condemnation Number of parcels _____	2.
		Wrongful Eviction (33)	<input type="checkbox"/> A6023 Wrongful Eviction Case	2., 6.
Real Property	Other Real Property (26)	<input type="checkbox"/> A6018 Mortgage Foreclosure	2., 6.	
		<input type="checkbox"/> A6032 Quiet Title	2., 6.	
		<input type="checkbox"/> A6060 Other Real Property (not eminent domain, landlord/tenant, foreclosure)	2., 6.	
Unlawful Detainer	Unlawful Detainer-Commercial (31)	<input type="checkbox"/> A6021 Unlawful Detainer-Commercial (not drugs or wrongful eviction)	2., 6.	
	Unlawful Detainer-Residential (32)	<input type="checkbox"/> A6020 Unlawful Detainer-Residential (not drugs or wrongful eviction)	2., 6.	
	Unlawful Detainer-Post-Foreclosure (34)	<input type="checkbox"/> A6020F Unlawful Detainer-Post-Foreclosure	2., 6.	
	Unlawful Detainer-Drugs (38)	<input type="checkbox"/> A6022 Unlawful Detainer-Drugs	2., 6.	

LACIV 109 (Rev. 03/11)  
LASC Approved 03-04

**CIVIL CASE COVER SHEET ADDENDUM  
AND STATEMENT OF LOCATION**

Local Rule 2.0  
Page 2 of 4

American LegalNet, Inc.  
www.FamilyWorkFlow.com

SHORT TITLE:

ALMONT AMBULATORY v. UNITEDHEALTH GROUP, et al. I.

CASE NUMBER

	A Civil Case Cover Sheet Category No.	B Type of Action (Check only one)	C Applicable Reasons (See Step 3 Above)
Judicial Review	Asset Forfeiture (05)	<input type="checkbox"/> A6108 Asset Forfeiture Case	2., 6.
	Petition re Arbitration (11)	<input type="checkbox"/> A6115 Petition to Compel/Confirm/Vacate Arbitration	2., 5.
	Writ of Mandate (02)	<input type="checkbox"/> A6151 Writ - Administrative Mandamus <input type="checkbox"/> A6152 Writ - Mandamus on Limited Court Case Matter <input type="checkbox"/> A6153 Writ - Other Limited Court Case Review	2., 8. 2. 2.
	Other Judicial Review (39)	<input type="checkbox"/> A6150 Other Writ/Judicial Review	2., 8.
Provisionally Complex Litigation	Antitrust/Trade Regulation (03)	<input type="checkbox"/> A6003 Antitrust/Trade Regulation	1., 2., 8.
	Construction Defect (10)	<input type="checkbox"/> A6007 Construction Defect	1., 2., 3.
	Claims Involving Mass Tort (40)	<input type="checkbox"/> A6006 Claims Involving Mass Tort	1., 2., 8.
	Securities Litigation (28)	<input type="checkbox"/> A6035 Securities Litigation Case	1., 2., 8.
	Toxic Tort Environmental (30)	<input type="checkbox"/> A6036 Toxic Tort/Environmental	1., 2., 3., 8.
	Insurance Coverage Claims from Complex Case (41)	<input type="checkbox"/> A6014 Insurance Coverage/Subrogation (complex case only)	1., 2., 5., 8.
Enforcement of Judgment	Enforcement of Judgment (20)	<input type="checkbox"/> A6141 Sister State Judgment <input type="checkbox"/> A6160 Abstract of Judgment <input type="checkbox"/> A6107 Confession of Judgment (non-domestic relations) <input type="checkbox"/> A6140 Administrative Agency Award (not unpaid taxes) <input type="checkbox"/> A6114 Petition/Certificate for Entry of Judgment on Unpaid Tax <input type="checkbox"/> A6112 Other Enforcement of Judgment Case	2., 9. 2., 6. 2., 9. 2., 8. 2., 8. 2., 8., 9.
	RICO (27)	<input type="checkbox"/> A6033 Racketeering (RICO) Case	1., 2., 8.
	Other Complaints (Not Specified Above) (42)	<input type="checkbox"/> A6030 Declaratory Relief Only	1., 2., 8.
		<input type="checkbox"/> A6040 Injunctive Relief Only (not domestic/harassment)	2., 8.
		<input type="checkbox"/> A6011 Other Commercial Complaint Case (non-tort/non-complex)	1., 2., 8.
		<input type="checkbox"/> A6000 Other Civil Complaint (non-tort/non-complex)	1., 2., 8.
Miscellaneous Civil Petitions	Partnership Corporation Governance (21)	<input type="checkbox"/> A6113 Partnership and Corporate Governance Case	2., 8.
	Other Petitions (Not Specified Above) (43)	<input type="checkbox"/> A6121 Civil Harassment <input type="checkbox"/> A6123 Workplace Harassment <input type="checkbox"/> A6124 Elder/Dependent Adult Abuse Case <input type="checkbox"/> A6190 Election Contest <input type="checkbox"/> A6110 Petition for Change of Name <input type="checkbox"/> A6170 Petition for Relief from Late Claim Law <input type="checkbox"/> A6100 Other Civil Petition	2., 3., 9. 2., 3., 9. 2., 3., 9. 2. 2., 7. 2., 3., 4., 8. 2., 9.

LACIV 109 (Rev. 03/11)

LASC Approved 03-04

### CIVIL CASE COVER SHEET ADDENDUM AND STATEMENT OF LOCATION

Local Rule 2.0

Page 3 of 4

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SHORT TITLE:  
ALMONT AMBULATORY v. UNITEDHEALTH GROUP, et al.

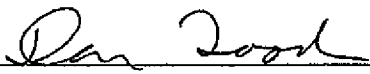
CASE NUMBER

Item III. Statement of Location: Enter the address of the accident, party's residence or place of business, performance, or other circumstance indicated in Item II., Step 3 on Page 1, as the proper reason for filing in the court location you selected.

REASON: Check the appropriate boxes for the numbers shown under Column C for the type of action that you have selected for this case.  <input type="checkbox"/> 1. <input type="checkbox"/> 2. <input checked="" type="checkbox"/> 3. <input type="checkbox"/> 4. <input type="checkbox"/> 5. <input type="checkbox"/> 6. <input type="checkbox"/> 7. <input type="checkbox"/> 8. <input type="checkbox"/> 9. <input type="checkbox"/> 10.		ADDRESS: 269 S. Beverly Drive Suite 1409
city: Beverly Hills	STATE: CA	ZIP CODE: 90212

Item IV. Declaration of Assignment: I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct and that the above-entitled matter is properly filed for assignment to the Los Angeles County courthouse in the Central District of the Superior Court of California, County of Los Angeles [Code Civ. Proc., § 392 et seq., and Local Rule 2.0, subds. (b), (c) and (d)].

Dated: March 21, 2014

  
 (SIGNATURE OF ATTORNEY/FILING PARTY)  
 Daron Toooh

**PLEASE HAVE THE FOLLOWING ITEMS COMPLETED AND READY TO BE FILED IN ORDER TO PROPERLY COMMENCE YOUR NEW COURT CASE:**

1. Original Complaint or Petition.
2. If filing a Complaint, a completed Summons form for issuance by the Clerk.
3. Civil Case Cover Sheet, Judicial Council form CM-010.
4. Civil Case Cover Sheet Addendum and Statement of Location form, LACIV 109, LASC Approved 03-04 (Rev. 03/11).
5. Payment in full of the filing fee, unless fees have been waived.
6. A signed order appointing the Guardian ad Litem, Judicial Council form CIV-010, if the plaintiff or petitioner is a minor under 18 years of age will be required by Court in order to issue a summons.
7. Additional copies of documents to be conformed by the Clerk. Copies of the cover sheet and this addendum must be served along with the summons and complaint, or other initiating pleading in the case.



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County Of Los Angeles

MAR 21 2014

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By: Amber Hayes, Deputy

DARON L. TOOCH (State Bar No. 137269)  
ERIC D. CHAN (State Bar No. 253082)  
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Attorneys for Plaintiffs

BY FAX

**SUPERIOR COURT OF THE STATE OF CALIFORNIA**

**COUNTY OF LOS ANGELES, CENTRAL DISTRICT**

ALMONT AMBULATORY SURGERY  
CENTER, LLC, a California limited liability  
company; BAKERSFIELD SURGERY  
INSTITUTE, LLC, a California limited  
liability company; INDEPENDENT  
MEDICAL SERVICES, INC., a California  
corporation; MODERN INSTITUTE OF  
PLASTIC SURGERY & ANTIAGING, INC.,  
a California corporation; NEW LIFE  
SURGERY CENTER, LLC, a California  
limited liability company, dba BEVERLY  
HILLS SURGERY CENTER; ORANGE  
GROVE SURGERY CENTER, LLC, a  
California limited liability company; SAN  
DIEGO AMBULATORY SURGERY  
CENTER, LLC, a California limited liability  
company; SKIN CANCER &  
RECONSTRUCTIVE SURGERY  
SPECIALISTS OF BEVERLY HILLS, INC.,  
a California corporation  
VALENCIA AMBULATORY SURGERY  
CENTER, LLC, a California limited liability  
company; WEST HILLS SURGERY  
CENTER, LLC, a California limited liability  
company,

Plaintiffs,

vs.

UNITEDHEALTH GROUP, INC.; UNITED  
HEALTHCARE SERVICES, INC.,  
UNITEDHEALTHCARE INSURANCE  
COMPANY; OPTUMINSIGHT, INC., and  
DOES 1 through 20,

Defendants.

CASE NO.

8C540056

COMPLAINT FOR:

1. VIOLATION OF BUSINESS AND  
PROFESSIONS CODE SECTION  
17200, et seq.
2. BREACH OF IMPLIED-IN-FACT  
CONTRACTS
3. SERVICES RENDERED
4. ESTOPPEL
5. DECLARATORY RELIEF

Trial Date:

None Set

**JURY TRIAL DEMANDED**

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1157465.1

COMPLAINT

COPY

1 Plaintiffs Almont Ambulatory Surgery Center, LLC, Bakersfield Surgery Institute, LLC,  
 2 Independent Medical Services, Inc., Modern Institute Of Plastic Surgery & Antiaging, Inc., New  
 3 Life Surgery Center, LLC dba Beverly Hills Surgery Center, Orange Grove Surgery Center, LLC,  
 4 San Diego Ambulatory Surgery Center, LLC, Skin Cancer & Reconstructive Surgery Specialists  
 5 Of Beverly Hills, Inc., Valencia Ambulatory Surgery Center, LLC, and West Hills Surgery Center,  
 6 LLC (collectively, the "Plaintiff Providers") bring this action, alleging as follows:

## 7 **II. INTRODUCTION**

8 1. This lawsuit alleges a deliberate, willful and concerted effort by United Healthcare  
 9 to indefinitely avoid paying for Lap-Band services for its morbidly obese members.

10 2. The patients whose claims are at issue in this lawsuit are all morbidly obese  
 11 individuals who are suffering from serious medical problems associated with their obesity.

12 3. All of these patients choose Preferred Provider Organization ("PPO") insurance,  
 13 rather than HMO insurance, through their employers so that they could receive their medical  
 14 services from the physicians and other medical providers of their choice, regardless of whether  
 15 those physicians are in-network or out-of-network. United Healthcare, who administers the PPO  
 16 insurance for these employers, advertises that the benefits of its PPO policy include: "The  
 17 freedom to choose any doctor for your health care needs."

18 4. All of these patients requested and received authorization from United Healthcare  
 19 to undergo the extensive pre-operative tests necessary to determine whether they are qualified to  
 20 receive Lap-Band surgery. After receiving the authorizations, the patients went through months of  
 21 pre-operative tests.

22 5. Despite authorizing the procedures, United Healthcare has refused to pay for the  
 23 vast majority of the tests.

24 6. In some cases, United Healthcare authorized the patients to receive the Lap-Band  
 25 surgery. However, despite authorizing the surgeries, United Healthcare has refused to pay for the  
 26 surgeries.

27 7. United Healthcare has created a number of pretextual excuses for refusing to  
 28 process or to pay the claims. The most common excuse is that it needs certain medical records

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1 from the patients' healthcare providers – the plaintiffs in this case. However, the plaintiff  
 2 healthcare providers have provided all the medical records to United Healthcare on multiple  
 3 occasions. Nevertheless, United Healthcare continues to falsely claim that it needs additional  
 4 records.

5 8. When the healthcare providers call United Healthcare to ask what records are  
 6 missing, United Healthcare cannot say what records are missing. Instead, the United Healthcare  
 7 representatives who answer the phones say that United's claims processor, Optuminsight, which is  
 8 located in the Philippines, says that it is missing records, but cannot tell United Healthcare what  
 9 records are missing.

10 9. United Healthcare, on behalf of the employer defendants, therefore delays paying  
 11 for any of the claims by repeatedly asserting that it needs unspecified medical records, but cannot  
 12 state what records are missing. In fact, United Healthcare has all the medical records for all the  
 13 claims at issue in this case.

14 10. Many patients have been afraid to have the Lap-Band surgeries, even though their  
 15 insurance covers the surgeries and they are authorized to have them, because they do not want to  
 16 be saddled with the liability for paying for the surgeries given that United Healthcare has refused  
 17 to pay for any of the pre-operative tests.

18 11. Some patients have had the Lap-Band surgeries and need to have their Lap-Bands  
 19 adjusted because they have lost weight, or require other follow-up medical procedures related to  
 20 their surgeries. However, these patients are afraid to have these follow-up procedures because  
 21 they do not want to further increase their liability for payment due to United Healthcare's failure  
 22 to pay.

23 12. The refusal of United Healthcare to pay for the Lap-Band procedures for their  
 24 morbidly obese members and employees constitutes discrimination against morbidly obese  
 25 individuals and unfair business acts and practices in violation of California Business and  
 26 Professions Code section 17200, *et seq.*

13. This case does not involve claims which are governed by the Employee Retirement Income Security Act of 1974 ("ERISA"). Those claims are the subject of a concurrently filed federal court action.

14. Plaintiffs bring these claims in their own right and not based on any assignment of benefits.

15. Millions of dollars are owed by defendants for the services plaintiffs healthcare providers have provided to defendants' members and insureds.

**A. Plaintiffs Provide Much-Needed Health Care to Morbidly Obese Patients.**

16. Plaintiffs Almont Ambulatory Surgery Center, LLC, Bakersfield Surgery Institute, LLC, Independent Medical Services, Inc., Modern Institute Of Plastic Surgery & Antiaging, Inc., New Life Surgery Center, LLC dba Beverly Hills Surgery Center, Orange Grove Surgery Center, LLC, San Diego Ambulatory Surgery Center, LLC, Skin Cancer & Reconstructive Surgery Specialists Of Beverly Hills, Inc., Valencia Ambulatory Surgery Center, LLC, and West Hills Surgery Center, LLC are a network of health providers that specialize in providing laparoscopic adjustable gastric band ("Lap-Band") surgery and other surgical procedures and medical services to individuals who are morbidly obese.

17. Lap-Band surgery is a widely used and minimally invasive surgical procedure that involves tying a silicone band around a portion of the stomach pouch. Individuals who receive this procedure experience a feeling of satiety, or fullness, more quickly, and therefore eat less, which in turn promotes weight loss. Compared to other forms of bariatric surgery, such as gastric sleeve surgery or gastric bypass procedures, one expert publicly commented that "Lap-Band really has the fewest complications and is the least invasive."<sup>1</sup>

18. Since 2010, Plaintiffs have helped thousands of morbidly obese individuals to undergo Lap-Band surgery as well as other medical procedures that assist those individuals in

<sup>1</sup> ABC News, Christie's Weight-Loss Surgery: Less Invasive but Slower Weight Loss, May 7, 2013, <http://abcnews.go.com/Health/chris-christies-lap-band-surgery-left-stomach-intact/story?id=19126013> (comments of Dr. Richard Besser, ABC News' chief health and medical correspondent, regarding the recent announcement by New Jersey governor Chris Christie that he had received Lap-Band surgery).

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1 obtaining effective treatment for their disability. Plaintiffs estimate that roughly 90% of their  
 2 patients are morbidly obese.

3 19. The Equal Employment Opportunity Commission has formally recognized  
 4 "severe" or "morbid" obesity as a disability under the Americans with Disabilities Act, 42 U.S.C.  
 5 §12101 *et seq.* Morbidly obese individuals are therefore protected from discrimination based  
 6 upon their disability status. This includes discrimination with respect to the provision of health  
 7 care benefits that those individuals obtain through their employer.

8 20. Indeed, the morbidly obese, who represent nearly 4% of America's population, are  
 9 frequently discriminated against in the provision of medical care. This trend was illustrated by a  
 10 recent blog post in the New York Times, which reported that in a recent study, one out of five  
 11 doctors' offices in four major cities across the country refused to even book an appointment when  
 12 researchers attempted to do so on behalf of a hypothetical overweight, disabled patient, and made  
 13 unfounded assumptions about that patient without even meeting him.<sup>2</sup> The Provider Plaintiffs  
 14 therefore perform a valuable role in providing much-needed care to an underserved and  
 15 misunderstood population.

16 **B. Defendants' Blanket Refusal to Pay for Plaintiffs' Services Continues to Cause**  
 17 **Serious and Ongoing Harm to Patient Care.**

18 21. This lawsuit arises from a deliberate, willful and concerted effort by Defendants  
 19 UnitedHealth Group, Inc., United Healthcare Services, and UnitedHealthcare Insurance Company  
 20 (collectively, "United") to indefinitely avoid paying for services that Plaintiffs rendered to their  
 21 largely morbidly obese patient population.

22 22. Plaintiffs are not members of UnitedHealth Group's in-network health care  
 23 providers, and they are not signatories to any contracts with UnitedHealth Group. Each of the  
 24 claims which Plaintiffs submitted was pursuant to an authorization that they obtained from United  
 25 prior to the procedure being performed. In fact, for nearly every claim, United represented in

26 \_\_\_\_\_  
 27 <sup>2</sup> Pauline W. Chen, New York Times Well Blog, May 23, 2013, *Disability and Discrimination at*  
 28 *the Doctor's Office*, <http://well.blogs.nytimes.com/2013/05/23/disability-and-discrimination-at-the-doctors-office/> (last visited June 3, 2013).

1 response to inquiries by the various Plaintiff providers that they would reimburse the cost of the  
 2 procedure at the provider's "usual and customary rates" ("UCR"). In reality, however, United  
 3 had no intention of paying anything at all.

4       1.       **United Schemed to Withhold All Payment from Plaintiffs, And Then Lied**  
 5               **About It.**

6       23.     In 2010, Plaintiffs began submitting claims for reimbursement to United. Initially,  
 7 United paid such claims. Beginning in 2010, however, United started to substantially underpay  
 8 Plaintiffs' claims for reimbursement, and shortly thereafter, began to systematically withhold all  
 9 payment from Plaintiffs without informing them. United did so even though for many patients it  
 10 had expressly given authorization for the procedures at issue to be performed. In many cases, the  
 11 providers and surgery centers performed these surgeries in reliance upon United's prior  
 12 authorizations. Despite authorizing the procedures, however, United refuses to pay – and in some  
 13 cases, even refuses to process – virtually any claim that is submitted by the Plaintiffs.

14       24.     United accomplishes this delay in processing claims by using a variety of made-up  
 15 excuses, all of which are procedurally improper. Each time the Plaintiffs submit claims for  
 16 services rendered, United responds with a boilerplate notification that the claim cannot be  
 17 processed without additional, burdensome documentation, most of which is already in the  
 18 possession of United, and none of which is needed to process the claims. In many cases, United  
 19 asks for numerous categories of medical records which it either already has, or which are not  
 20 relevant to the claim being processed. In other cases, pretends not to have received the claim at  
 21 all, or pretends not to have received medical records that Plaintiffs have submitted, forcing  
 22 Plaintiffs to re-submit them. When Plaintiffs follow up to ask what information is required to  
 23 perfect its claims United refuses to identify which specific records it supposedly needs. Despite  
 24 having all the information it needs to process Plaintiffs' valid claim submissions, United almost  
 25 always denies Plaintiffs' claims for the purported failure to provide all relevant medical records.

26       25.     United also forwards nearly every claim submitted by the Plaintiffs to Defendant  
 27 OptumInsight, Inc. (also known as Ingenix) for purported further "review," where those claims  
 28 may languish for months and years without being paid. Ingenix/OptumInsight makes the same

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1 unintelligible, burdensome and baseless requests for records and documentation as United, even  
 2 when Plaintiffs have previously provided all of the same medical records and other documents to  
 3 United in response to the same requests. Ingenix/OptumInsight also refuses to identify what  
 4 specific records are supposedly necessary to perfect the claims for payment. As a result, Plaintiffs  
 5 are ping-ponged back and forth between United and Ingenix in what are ultimately futile attempts  
 6 to understand what further information United supposedly needs to pay the claims.

7 26. California law requires United to state the specific reason it is asserting for denial  
 8 of a claim. Insurance Code § 10123.13; Health and Safety Code § 1371. United's denial letters  
 9 did not advise Plaintiffs of the specific reasons for denial of the claims. United's denial letters  
 10 also did not advise Plaintiffs of the true reasons for denial of the claims. In other words, United  
 11 had no intention of paying Plaintiffs' claims, but was simply making up excuses for non-payment  
 12 of the claims.

13 27. United's communications with Plaintiffs are not only deceptive, in that they are  
 14 intended to obfuscate United's true intent, which is to deny any claim submitted by Plaintiffs.  
 15 After months or years of delay, United ultimately relies on the same intentionally dishonest,  
 16 inadequate and spurious excuses to deny payment such as the purported failure to provide the  
 17 "complete" medical records.

18 28. Through this deliberate and institutionalized abuse of the claims administration  
 19 process, United has, in effect, successfully managed to avoid paying nearly any of Plaintiffs'  
 20 claims for the past three years. The amount that United owes Plaintiffs, in the aggregate, on these  
 21 unpaid claims is in excess of three million dollars.

22 29. United's scheme of denials and cryptic claim rejections ensure that Plaintiffs never  
 23 know why their claims are being denied in violation of United's obligations to convey complete  
 24 and accurate information.

25 30. On information and belief, the terms of the health benefit plans administered by  
 26 United do not permit United to deny Plaintiffs' claims, nor do they permit United to obstruct,  
 27 delay, or draw out the claims process for years at a time.

28

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31. Moreover, on information and belief, United was fully aware that roughly 90% of the patients who came to Plaintiffs were morbidly obese, a protected class, and in need of surgical treatment to ameliorate their condition. United's discriminatory treatment of Plaintiffs' morbidly obese patients was therefore also in violation of applicable state and federal law, including the federal Americans with Disabilities Act and California's Fair Employment and Housing Act.

**2. Plaintiffs Will Suffer Irreparable Harm, Including Harm to Their Ability to Care for Existing Patients, Unless United is Ordered to Stop.**

32. Plaintiffs and their morbidly obese patients have been, and continue to be, seriously harmed by United's behavior. United never directly and unambiguously informed Plaintiffs that it intended to deny payment on each and every claim. In fact, it continued to verify the availability of benefits whenever Plaintiffs inquired regarding new patients, and continued to authorize medical procedures for those patients to be performed by the Plaintiffs. In fact, during insurance verification calls, United consistently assured Plaintiffs that they would pay the reasonable and customary fees charged by Plaintiffs for their services. In reliance upon United's representations that benefits were available and that procedures would be authorized and United's promises to pay their reasonable and customary charges, Plaintiffs reasonably expected their claims would be paid and continued to see United policyholders, to their detriment.

33. United is the single largest payor for Plaintiffs, such that a very substantial percentage of all Plaintiffs' patients have benefit plans are funded and/or administered by United. United's surreptitious and dishonest scheme to withhold payment is, quite literally, driving Plaintiffs out of business.

34. United's actions also threaten the continuity of patient care. For instance, United frequently authorized initial procedures and the work-up necessary to perform bariatric surgery, and in some cases, even paid for the initial work-up, but then denied payment for surgical procedures that were performed. This prevents Plaintiffs' morbidly obese patients from receiving the treatment they desperately need to help them lose weight. Likewise, patients who have received Lap-Band surgery must return to Plaintiffs on a regular basis to receive adjustments to the Lap-Band, yet it is difficult to continue to provide care when United has still failed to pay for

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1 the initial procedure. For such patients, Plaintiffs cannot simply stop providing care, as that might  
 2 constitute patient abandonment under California law.

3 35. United is also depriving its own insureds of the health benefits to which they are  
 4 entitled. As patients acknowledge when they come to Plaintiffs for treatment, they are financially  
 5 responsible in the event that United does not pay. Because United authorizes procedures  
 6 performed by the Plaintiff providers and yet does not paid anything on the resulting claims,  
 7 Plaintiffs are being placed into an adversarial position with respect to their patients. Of course,  
 8 this is a costly, unpleasant, and uncertain process, and results in the loss of the peace of mind that  
 9 insureds are entitled to enjoy.

10 36. Patient care will continue to be endangered unless this Court enjoins United's  
 11 behavior, and orders United to cease abusing the claims review process as a way to indefinitely  
 12 avoid paying Plaintiffs what they are entitled to be paid under the terms of the patients' benefit  
 13 plans. Injunctive relief is necessary in order to stop United from hiding behind the curtain of  
 14 arbitrary administrative process, and to force United to process Plaintiffs' claims according to the  
 15 terms of applicable benefit plans. Otherwise, patient care and peace of mind will continue to be  
 16 endangered, causing irreparable harm to Plaintiffs' ability to care for its patients.

17 **C. In Addition to Refusing to Pay, United Imposed Arbitrary and Discriminatory**  
 18 **Barriers to Patients Obtaining Surgery.**

19 37. On information and belief, there was an overarching, and undisclosed, policy at  
 20 United to withhold all payment for submitted by patients who utilized their out-of-network  
 21 benefits with Plaintiffs, even though Defendants were fully aware that roughly 90% of the patients  
 22 who came to the Plaintiffs were morbidly obese and in need of surgical treatment to ameliorate  
 23 their condition.

24 38. On information and belief, as part of this unwritten policy, Defendants created  
 25 unreasonable barriers for morbidly obese patients seeking to obtain the weight loss surgery offered  
 26 by Plaintiffs constituted unlawful discrimination as well as an arbitrary and capricious denial of  
 27 health benefits. Such benefits could and should have been made available under the health plans  
 28 administered and/or funded by United.

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1           39.     For instance, United began denying approval for certain procedures until the  
2 individuals seeking surgery enrolled in, and completed, a six-month weight loss plan and nutrition  
3 regimen. United knew that nothing in the terms of many of those individuals' health benefit plans  
4 required such draconian steps. It also knew the patients' physicians had already determined that  
5 Lap-Band surgery was medically necessary.

6           40.     Studies published in numerous well-regarded scientific journals have found that  
7 such weight loss programs were ineffective for the morbidly obese and did not lead to better  
8 clinical outcomes than bariatric surgery alone. Individuals who enroll in such arbitrarily imposed  
9 six-month plans typically drop out and do not lose weight; in any case, United's weight loss plans  
10 typically do not even require a demonstration that weight loss has occurred. Thus, the net effect of  
11 this arbitrary and capricious barrier was to prevent morbidly obese plan beneficiaries from  
12 acquiring much-needed surgery.

13           41.     Along the same lines, United raised an unreasonable impediment to approval by  
14 seeking written proof from a doctor's office of the patient's weight or body mass index (BMI) for  
15 each of the preceding five years to be eligible for surgery. If the morbidly obese patient did not  
16 visit a doctor and thus did not have a documented weight in just one of the previous 5 years, the  
17 request would be denied. Like the preoperative weight loss plans, this was not a requirement of  
18 many of the health benefit plan prior to the approval of bariatric surgery, and was an arbitrary and  
19 capricious barrier to prevent morbidly obese beneficiaries from obtaining surgery.

20           42.     United, as the designated claims administrator for the plans, exercised sole  
21 discretion over claim pricing and payment of Plaintiffs' claims, and was responsible for  
22 authorizing medical treatment for its members. On information and belief, however, the terms of  
23 many patients' benefit plans did not make surgery benefits contingent upon barriers such as the  
24 completion of a six month weight-loss plan, or a five-year documentation of the patient's weight.  
25 United's refusal to approve many of these procedures until these arbitrary requirements had been  
26 met constituted arbitrary and capricious conduct that went beyond United's fiduciary duties to  
27 interpret and administer the terms of the plans.  
28

43. As with United's pretextual denials of payment for medical procedures actually performed, United's imposition of such barriers also constituted wrongful discrimination and failure to reasonably accommodate these patients' disabilities under both the federal Americans with Disabilities Act and California's Fair Employment and Housing Act. As a result, United has also engaged in unfair competition under California's Unfair Competition Law, and should be enjoined from denying benefits to its insured based on such conduct.

### III. THE PARTIES

#### A. Plaintiff Surgery Centers

44. The Plaintiff Surgery Centers are Limited Liability Companies and Corporations organized and existing under the laws of the State of California, with their principal places of business in the State of California. Plaintiff Surgery Centers operate ambulatory surgery centers that provide a variety of surgical services, including but not limited to the Lap-Band procedure. At all relevant times, none of the Plaintiff Surgery Centers were under contract with any of the Defendants, and none of them participated in any of Defendants' provider networks.

a) Plaintiff Almont Ambulatory Surgery Center LLC is, and at all relevant times was, a California limited liability company organized and existing under the laws of the State of California, with its principal place of business in Beverly Hills, California. Plaintiff Almont Ambulatory Surgery Center operates an ambulatory surgery center in Beverly Hills, California. At all relevant times, Almont Ambulatory Surgery Center was not under contract with any of the Defendants, and did not participate in any of their provider networks.

b) Plaintiff Bakersfield Surgery Institute, LLC is, and at all relevant times was, a limited liability company organized and existing under the laws of the State of California, with its principal place of business in Bakersfield, CA. Plaintiff Bakersfield Surgery Institute, LLC operates an ambulatory surgery center in Bakersfield, California. At all relevant times, Bakersfield Surgery Institute, LLC was not under contract with any of the Defendants, and did not participate in any of their provider networks.

c) Plaintiff Modern Institute of Plastic Surgery & Antiaging, Inc. ("Modern Institute") is, and at all relevant times was, a California corporation organized and existing under

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the laws of the State of California, with its principal place of business in Beverly Hills, California. Plaintiff Modern Institute operates an ambulatory surgery center in Beverly Hills, California specializing in plastic surgery and also in bariatric surgery, including the Lap-Band procedure. At all relevant times, Plaintiff Modern Institute was not under contract with any of the Defendants, and did not participate in any of their provider networks.

d) Plaintiff New Life Surgery Center LLC dba Beverly Hills Surgery is, and at all relevant times was, a limited liability company organized and existing under the laws of the State of California, with its principal place of business in Beverly Hills, California. Plaintiff New Life Surgery Center LLC operates an ambulatory surgery center in Beverly Hills, California specializing in bariatric surgery, including in the Lap-Band procedure. At all relevant times, New Life Surgery Center LLC was not under contract with any of the Defendants, and did not participate in any of their provider networks.

e) Plaintiff Orange Grove Surgery Center, LLC is, and at all relevant times was, a limited liability company organized and existing under the laws of the State of California, with its principal place of business in Pomona, CA. Plaintiff Orange Grove Surgery Center, LLC operates an ambulatory surgery center in Pomona, California. At all relevant times, Orange Grove Surgery Center, LLC was not under contract with any of the Defendants, and did not participate in any of their provider networks.

f) Plaintiff San Diego Ambulatory Surgery Center, LLC is, and at all relevant times was, a limited liability company organized and existing under the laws of the State of California, with its principal place of business in San Diego, CA. Plaintiff San Diego Ambulatory Surgery Center, LLC operates an ambulatory surgery center in San Diego, California. At all relevant times, San Diego Ambulatory Surgery Center, LLC was not under contract with any of the Defendants, and did not participate in any of their provider networks.

g) Plaintiff Skin Cancer & Reconstructive Surgery Specialists of Beverly Hills ("Reconstructive Specialists") is, and at all relevant times was, a California corporation organized and existing under the laws of the State of California, with its principal place of business in Beverly Hills, California. Plaintiff Skin Cancer & Reconstructive Surgery Specialists of Beverly

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Hills operates an ambulatory surgery center in Beverly Hills, California. At all relevant times, Plaintiff Skin Cancer & Reconstructive Surgery Specialists of Beverly Hills was not under contract with any of the Defendants, and did not participate in any of their provider networks.

h) Plaintiff Valencia Ambulatory Surgery Center, LLC is, and at all relevant times was, a limited liability company organized and existing under the laws of the State of California, with its principal place of business in Valencia, CA. Plaintiff Valencia Ambulatory Surgery Center, LLC operates an ambulatory surgery center in Valencia, California. At all relevant times, Valencia Ambulatory Surgery Center, LLC was not under contract with any of the Defendants, and did not participate in any of their provider networks.

i) Plaintiff West Hills Surgery Center LLC is, and at all relevant times was, a limited liability company organized and existing under the laws of the State of California, with its principal place of business in West Hills, California. Plaintiff West Hills Surgery Center LLC operates an ambulatory surgery center in West Hills, California. At all relevant times, West Hills Surgery Center LLC was not under contract with any of the Defendants, and did not participate in any of their provider networks.

**B. Plaintiff Independent Medical Service**

45. Plaintiff Independent Medical Service, Inc. ("IMS") is, and at all relevant times was, a California professional corporation organized and existing under the laws of the State of California, with its principal place of business in Beverly Hills, California. IMS is a physicians' medical group that bills for professional services. At all relevant times, IMS was not under contract with any of the Defendants, nor did they participate in any of Defendants' provider networks.

**C. United Defendants**

46. Plaintiffs are informed and believe that Defendant UnitedHealth Group, Inc. ("UnitedHealth") is a Minnesota corporation with its corporate headquarters located in Minneapolis, Minnesota. Defendant UnitedHealth Group is a publicly traded corporation which is not qualified to do business in the State of California, but is engaged in business in the State of

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1 California and County of Los Angeles through its subsidiaries UnitedHealthcare Insurance  
2 Company, and United HealthCare Services, Inc.

3 47. Plaintiffs are informed and believe that Defendant UnitedHealthcare Insurance  
4 Company ("UHIC") is a corporation organized and existing under the laws of the State of  
5 Connecticut, a wholly owned and controlled subsidiary of Defendant UnitedHealth Group, with its  
6 principal place of business in Connecticut. Defendant UHIC is qualified to engage in business in  
7 the State of California and engaged in business in the Country of Los Angeles as an insurance  
8 company.

9 48. Plaintiffs are informed and believe that Defendant United HealthCare Services, Inc.  
10 ("United HealthCare") is a Minnesota corporation with its corporate headquarters located in  
11 Minneapolis, Minnesota. United HealthCare is wholly-owned by UnitedHealth, and serves as  
12 UnitedHealth's operating division. United HealthCare is licensed to conduct insurance operations  
13 in California and, on information and belief, every other State in the United States, whether it be  
14 under the name United HealthCare or some other operating name.

15 49. Plaintiffs are informed and believes that Defendant OptumInsight, Inc. ("Optum")  
16 is a Delaware corporation with its corporate headquarters located in Eden Prairie, Minnesota.  
17 Plaintiff is informed and believes that as of April 2011, Ingenix, Inc. also has been doing business  
18 under the trade name "Optum."<sup>3</sup> Optum is a wholly-owned subsidiary of UnitedHealth

19 50. UnitedHealth, United Healthcare, UHIC, and Optum/Ingenix will be collectively  
20 referred to herein as "United" or the "United Defendants."

21 51. With respect to all of the claims at issue herein, Plaintiffs are informed and believe  
22 that the United Defendants:

- 23 a) drafted and provided plan members with plan documents;
- 24 b) operated a centralized verification and authorization telephone number
- 25 which handled calls for members;

26 \_\_\_\_\_  
27 <sup>3</sup> See OptumInsight News Room, April 11, 2011 press release, UnitedHealth Group Announces  
28 "Optum" Master Brand for its Health Services Businesses, <http://www.optuminsight.com/news-events/press-releases/2011/457/>

- c) authorized Plaintiffs to provide medical services to beneficiaries;
- d) received and processed electronic bills from Plaintiffs;
- e) communicated with Plaintiffs regarding authorization of surgical procedures;
- f) issued remittance advices and EOBs;
- g) priced claims;
- h) communicated with Plaintiffs with respect to the processing of claims;
- i) processed appeals, and sent appeal response letters; and
- j) issued payment.

#### IV. GENERAL ALLEGATIONS

##### A. United's Health Insurance Business

52. United is one of the nation's largest health insurers. It underwrites and issues thousands of health insurance plans. It also contracts with other entities that provide health benefits in order to provide administrative services for those entities' health plans, such as claim pricing.

53. Individuals who do not receive employer-sponsored health insurance often purchase health insurance policies directly from United, who typically has sole responsibility and discretion to administer and pay claims submitted under such policies.

54. When the plan is insured by United, United not only is responsible for administering a claim brought under the plan, but is also financially responsible for the payment of the claim. United provides plan members with plan documents, interprets and applies the plan terms, makes coverage and benefits decisions, handles appeals of coverage and benefits decisions, and provides for payment in the form of medical reimbursements.

##### 1. Out-Of-Network UCR Reimbursement

55. Various ambulatory surgery centers in the industry, other than the Provider Plaintiffs, have written contracts with United under which they agree to accept United's set and scheduled reimbursement that is discounted from the centers' total billed charges. In exchange, these "in network" providers receive referrals of patients from United and the associated benefits

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1 of being a participating or "in-network" provider. These benefits typically include an increased  
 2 volume of business that results because the health plans provide financial incentives to their  
 3 members to utilize the services of "in-network" providers, such as reduced co-insurance payments  
 4 and/or deductibles.

5 56. Conversely, some surgery centers and physicians, such as the Plaintiffs, do not  
 6 have written contracts with United. They are "out-of-network." As a result, these surgery centers  
 7 and physicians receive less volume of patients from the plans, but they are not governed by any  
 8 contractual requirements of defendants' plans and they are not required to accept reduced amounts  
 9 as payment in full for their charges for the services rendered. They are free to charge whatever  
 10 amounts they deem appropriate for their services.

11 57. Typically, United pays benefits to in-network surgery centers at the lower, in-  
 12 network contract amount charged by those centers. However, benefit plans typically contain  
 13 provisions for paying out-of-network surgery centers and physicians at an UCR rate or a  
 14 percentage of the UCR rate. The language varies from plan to plan, and may be described as the  
 15 "Usual, Customary and Reasonable" rate, the "Reasonable and Customary" amount, the "Usual  
 16 and Customary" amount, the "Reasonable Charge," the "Prevailing Rate," the "Usual Fee," the  
 17 "Competitive Fee," or some other similar phrase. In the context of the healthcare industry, and in  
 18 United's own parlance, these phrases are all synonymous with UCR.

## 19 **2. Payment Authorizations and UCR Industry Standards**

20 58. When an out of network surgery center or health care provider has a patient who is  
 21 insured by United, the standard practice is to request authorization from United to provide out-of-  
 22 network services to that patient. United has developed a general practice and standard in the  
 23 industry to grant such authorizations. United does not impose its plan terms on such out-of-  
 24 network surgery centers and providers, but rather as a standard of custom and industry practice  
 25 commits to paying UCR no matter what the actual billed amount might be from the surgery center  
 26 or provider.

27 59. Whether the claims are from out-of-network or in-network surgery centers or  
 28 providers, when the claims are submitted to United, they reflect the actual billed charges for the

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1 claim. Even though in-network surgery centers and providers are sometimes reimbursed  
 2 according to contracted rates that include discounts, they still submit their full billed charges on  
 3 the claim. This is industry standard for all providers, and reflects the well-established fact that  
 4 charges are not the same as the discounted contract rates. Therefore, United has for many years  
 5 acquired a wealth of charge data from which it can use to price claims by comparing the prevailing  
 6 charges for similar healthcare services by similar types of surgery centers within the same  
 7 geographical market at the time.

8 60. No provisions in those benefit plans, whether in their Summary Plan Descriptions  
 9 (SPDs) and Evidences of Coverage (EOCs), justified the failure to pay the usual and customary  
 10 fees for services charged by outpatient surgical centers such as those managed and operated by the  
 11 Plaintiffs, and to instead pay nothing. It was arbitrary, capricious and improper for United to do  
 12 so. In fact, during the insurance verification process for most if not all of the patients in this case,  
 13 United represented to Plaintiffs that it would pay the Plaintiff Providers' usual and customary fees.  
 14 Plaintiffs sought information during this process about potential limitations on the reimbursement  
 15 of Plaintiffs fee each time prior to providing services, and specifically inquired each time prior to  
 16 providing services as to how United's fee provisions would apply to their situation. Defendants  
 17 withheld information in response to such requests, and therefore misled plaintiffs into thinking  
 18 that the entire Plaintiffs' usual and customary fees would be paid.

19 61. Likewise, no provisions anywhere in those plans justified the failure to issue a final  
 20 decision or denial on any of Plaintiffs' claims. This was therefore arbitrary, capricious, and a  
 21 breach of United's fiduciary duties to plan participants. It was also a violation of California  
 22 statutes which require that claims be adjudicated by United within 30 working days after receipt of  
 23 the claim. Insurance Code § 10123.13; Health and Safety Code § 1371.

24 62. Moreover, despite making thousands of requests for plan documents and  
 25 information about United's UCR methodology, the Defendants failed to provide any of the  
 26 requested documents or information to Plaintiffs. Therefore, Plaintiffs have been unable to  
 27 confirm exactly how United purports to administer the terms of the benefit plans, or how United  
 28 prices Plaintiffs' claims.

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63. Even in those rare instances where Defendants paid Plaintiffs' claims, they paid far less than Plaintiffs' usual and customary fees. On information and belief, United did not uniformly apply UCR to all service providers in the same geographic area, and in fact, discriminated against the Plaintiffs.

**B. United's Systematic, Surreptitious, and Unlawful Withholding of Payment For Services Rendered**

64. United did not intend not to pay for the services rendered by Plaintiffs. Rather than inform Plaintiffs directly of this fact, however, United chose to carry out their intentions through subterfuge and deceit. Specifically, United manufactured various pretextual rationales unrelated to the actual benefits available under the plans in order to unlawfully prolong the claims administration process and ultimately deny Plaintiffs' claims outright on grounds not justified by the terms of the benefit plans.

65. United knows full well that the terms of Plaintiffs' benefit plans obligated it to pay Plaintiffs for the valuable medical services they had provided to beneficiaries and participants of those plans. United does not have the ability to substantively change the terms of the plans, or to create hurdles for beneficiaries to obtain such benefits, or new reasons for denial of such benefits that were contrary to, or inconsistent with, plan terms. Thus, in making up false reasons to withhold and deny payment from the Plaintiffs, United was acting beyond the scope of its authority, and abused its discretion.

66. In many cases, United conveyed these fabricated rationales to Plaintiffs by issuing Explanation of Benefits ("EOBs") forms, which United typically issues when a claims decision is made, or through appeal denial letters. Though these forms and letters purported to be claim denials, they contained no actual reasons explaining why the claim was being denied according to the terms of the applicable benefit plan, as required by state law. Instead, they merely requested additional documentation or suggested that further review was required.

67. Instead of responding to Plaintiffs' requests by providing access to the material that the regulations entitle Plaintiffs to review, Defendants elected to completely ignore and reject the requests, and make spurious and pretextual reasons for refusing to process and pay the claims.

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The spurious and pretextual tactics utilized by United included, but were not limited to, the following:

- Making repeated and redundant requests for medical records, even where records had already been provided on multiple occasions, and then denying in follow-up conversations that records had ever previously been received;
- Routinely requesting physician's orders approving the use of Durable Medical Equipment (DME) that Plaintiffs did not use or provide in connection with the medical services at issue;
- Forwarding all or nearly all of Plaintiffs' claims for "further review" by United's wholly owned subsidiary, Ingenix (also known as OptumInsight), and promising that review by Ingenix / OptumInsight would take 15-30 days, while in fact causing the so-called review to last for months or even years with no payment resulting from the "review";
- Requiring Plaintiffs to separately submit medical records or other documentation to Ingenix / OptumInsight when Plaintiffs had already submitted such documentation directly to United, on the pretextual ground that Ingenix / OptumInsight did not have access to the records that had already been submitted to United;
- Denying claims solely because the patients on whose behalf reimbursement was sought had allegedly failed to "authorize" Plaintiffs to appeal on their behalf, even though Plaintiffs always submitted a proper assignment of benefits demonstrating such authority, and even though Defendants in practice acknowledged that assignment had occurred by dealing directly with Plaintiffs, rather than with the patients;
- Claiming that one or more of the surgical facilities where the surgery was performed was not listed in United's database of health providers as a reason for non-payment, even though claims had previously been paid to those same facilities and even though United sometimes paid the surgeon who selected the facility;

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- Demanding surgery center licenses, even though California does not require any such license (surgery centers are “certified” by one or more entities, such as the Joint Commission on Accreditation for Health Care Organizations under Health & Safety Code § 1248 *et. seq.*);
- Denying claims for containing procedures with incorrect “modifier” codes, even though the claims that Plaintiffs submitted never included or required such codes;
- Denying claims because the patient purportedly did not have coverage, for instance, because of a pre-existing condition, when such coverage in fact existed;
- Denying claims on the basis that they were not timely filed, though Plaintiffs’ submissions were timely.

68. While the rationale for denying any given claim varied, the outcome was always the same: the complete denial of nearly all payment for surgeries and procedures performed by Plaintiffs. When examined closely, none of United’s rationales hold up to scrutiny. Yet they were repeatedly used to withhold payment to Plaintiffs, without informing Plaintiffs at any time of United’s true intent to do so.

69. United has admitted that it has received the Patients’ medical records, but intentionally uses its corporate structure to obscure the reasons for its failure to properly process and pay for claims. This deliberate and systematic obfuscation opacity has been glaringly apparent each time Plaintiffs have contacted United for guidance in understanding what additional records United supposedly needs to process and pay for the Patients’ claims. Plaintiffs have asked again and again for clarification as to what specific medical records United considers necessary to process the claims, and were rebuffed repeatedly. United’s responses offered no guidance as to how plaintiffs could perfect their claims. For example, United representatives have responded as follows in response to questions regarding what additional documents United requires to process the Patients’ claims:

- “So this claim on this date of service, looks like a different department, Optum Insight[, a.k.a. Ingenix], was requesting treatment records.”
- “I do show that it was submitted multiple times,... I’m showing that [Optum Insight, a.k.a. Ingenix] received the information but they’re still needing additional

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1 information. They said they received it and are unable to process it, meaning that  
 2 one or more items are missing, history and physical, um findings, meaning labs,  
 3 radiology, pathology, anesthesia, just things of that nature. Any op note, procedure  
 4 report, daily progress treatment records, medication notes, physician orders, um,  
 5 anything of that nature.... [M]aybe they'll be able to give you more, um, elaborate  
 6 information."

• "Um, actually, it's not [Optum Insight, a.k.a. Ingenix]... the request actually  
 7 would be the United Healthcare since technically it's them who has the right to  
 8 request those records, and then it would be routed to us [at Optum  
 9 Insight/Ingenix]."

• "[T]he thing is, we just need those medical records. I know you have  
 10 submitted them perhaps to a different department of United Healthcare, but as you  
 11 can see here, whatever goes to us are the only ones that was reviewed, and I do see  
 12 here a one page of lap band follow up visits, office visits."

• "The thing is, um, this one, actually, **we are not even communicating**  
 13 **directly to them.** We only have, um, certain departments who are handling this  
 14 and they're located in the United States, okay.... **[Optum Insight is located] in**  
 15 **the Philippines, for your commercial account.**"

• "Okay, so it initially shows that the claim was denied for incomplete  
 16 medical records. Then it is being indicated here that it was filed for an appeal. But  
 17 um that was received on 8/14 but basically that appeal is being closed out because  
 18 there's no patient authorization here.... So I just checked on the records here, one by  
 19 one and I'm going to have it sent back again to the appeals department about this  
 20 information because I can see that, um the... [assignment of] benefits as indicated  
 21 there. Also the op notes are also indicated there."

• "[I]t looks like what they're stating is that information was received but  
 22 some of the information was still missing that we needed. Um, and it doesn't tell  
 23 me specifically, just that it's – the information may have included the history and  
 24 physical findings upon examination, labs, radiology, pathology and anesthesia test  
 25 results, consult report."

26 70. Contrary to what the United representatives promised, Defendants had no intention  
 27 of processing or paying the claim even if Plaintiffs re-submitted the requested medical records.

28 71. Clearly, Defendant Ingenix/OptumInsight, to whom the United Defendants  
 delegated their responsibility for administering Plaintiffs' claims in a timely and accurate manner,  
 was in fact unqualified to do so. The delegation of the United Defendants' responsibilities to its  
 wholly owned subsidiary was not in order to facilitate the processing of Plaintiffs' claims, but to  
 delay it indefinitely, and to obscure from Plaintiffs the real reasons why Plaintiffs' claims were not  
 being paid.

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72. United's repeated requests for additional records, without specifying what particular records were missing, provided no meaningful guidance on what specific further evidence might be required.

**C. United Received Illegal Commissions In Return For Improperly Denying Plaintiffs' Claims**

73. Plaintiffs strongly suspect that another primary motivation that United had for denying Plaintiffs' claims is that United is substantially compensated by the Plans for doing so. Plaintiffs are informed and believe that when United refuses to pay the Plaintiffs for the services that they have rendered, it is paid a commission by the Plans, that is based upon a percentage of how much money the Plans "save" by not having to pay Plaintiffs their usual and customary fees. Thus, United effectively sets its own commission. This not only violates California law, but also violates the terms of the plans, which require usual and customary payment, as these artificial "savings," which are determined arbitrarily by United, bear no relation to a proper determination of Usual and Customary fees.

74. Plaintiffs are informed and believed that the Plans make these kickbacks to United pursuant to a program called the "Facility Reasonable Charge Determination Program" or the "Facility Reasonable & Customary Program," which the Plans agree to as part of their agreements with United by which United provides claims adjudication services for the Plans. The goal of the Facility Reasonable Charge Determination Program is to underpay, or even reject outright, claims made by ASCs such as the Plaintiff providers.

75. United is compensated under the Facility Reasonable Charge Determination Program at a specific percentage of the money that Defendants would otherwise have had to pay to Plaintiffs, had United correctly paid Plaintiffs' claims. This provided a major incentive for United to find ways not to pay Plaintiffs' claims, and to deny those claims on pretextual grounds, such as repeated and unfounded requests for irrelevant and nonexistent medical records.

76. United's receipt of kickbacks and/or commissions for denying Plaintiffs' claims is a clear and willful violation of California Health & Safety Code § 1399.56 and/or Insurance Code § 796.02, which provide that claims reviewers may not be compensated on the basis of (a) a

percentage of the amount by which a claim is reduced for payment; or (b) the number of claims or the cost of services that were denied and not paid. The Facility Reasonable Charge Determination Program is tied to precisely these illegitimate metrics.

**D. United Retaliated Against Plaintiffs and their Patients**

77. Further, United has retaliated against Plaintiffs and their Patients because Plaintiffs exercised the rights to which those participants and beneficiaries were entitled under their insurance policies.

78. Specifically, the patients who were treated by Plaintiffs lawfully attempted to exercise their rights and benefits under their respective plans to receive out-of-network payment.

79. However, for the sole reason that those participants and beneficiaries chose to receive care from the Plaintiffs at the Surgery Centers, United retaliated against the participants and beneficiaries, and by extension, against Plaintiffs.

80. Moreover, United also retaliated against Plaintiffs because Plaintiffs sought to appeal United's determinations denying payment.

81. Among other retaliatory measures, United directed the vast majority of Plaintiffs' claims to its Special Investigations Unit, known variously as Ingenix and/or OptumInsight. The United Defendants, including but not limited to Defendant Ingenix/OptumInsight, further retaliated against the Plaintiffs by generating various pretextual, unsupported, unwarranted and fraudulent reasons for prolonging the claims review process, including by repeatedly asking for medical records that did not exist and/or were not necessary to adjudicate the claims submitted by Plaintiffs.

**E. Defendants Have Discriminated Against Plaintiffs' Morbidly Obese Patients**

82. In addition to arbitrarily and capriciously withholding and/or denying payment, Defendants have actively discriminated against Plaintiffs' other potential patients who were morbidly obese, thus violating both the ADA and FEHA. Since passage of the Americans with Disabilities Act Amendments Act of 2008, which expanded the definition of disability, the EEOC has made clear that "severe" or "morbid" obesity is a recognized disability under the ADA.

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83. Title I of the ADA expressly prohibits employers from discriminating against a “qualified individual” (e.g., employee) on the basis of disability, including through “participating in a contractual... relationship that has the effect of subjecting a covered entity’s... employee with a disability to the discrimination prohibited by this subchapter (such relationship includes a relationship with an employment or referral agency, labor union, an organization providing fringe benefits to an employee of the covered entity, or an organization providing training and apprenticeship programs).” 42 U.S.C. § 12112 (emphasis added).

84. Likewise, California’s Fair Employment and Housing Act (FEHA) prohibits discrimination in the provision of such benefits on the basis of “physical disability” except where the discrimination is based upon a “bona fide occupational qualification.” Cal. Gov’t Code § 12940(a).

85. Moreover, employers, such as the Plans and their sponsors, must attempt to make good faith, reasonable accommodations for their employees’ disabilities, and the failure to do so is discriminatory. 42 U.S.C. § 12112(b)(5)(A); Cal. Gov’t Code § 12940(m). By not even attempting to accommodate morbidly obese individuals in their attempt to receive health benefits through their employers, Defendants have therefore discriminated against Plaintiffs’ patients who were morbidly obese, and/or aided and abetted employers in discriminating against their morbidly obese employees, by arbitrarily denying authorization and/or payment for Lap-Band surgery and related services, even though the employees’ plans clearly covered these procedures or should have covered those procedures in order to be considered non-discriminatory. Defendants did not deny authorizations or payment for other, non-morbidly obese patients.

**1. Defendants Targeted the Morbidly Obese for Discrimination.**

86. The requirement that patients participate in, and certify compliance with, a preoperative weight loss and diet regimen further constituted a prohibited “examination and inquiry” under the ADA “as to the nature or severity of the [patients’] disability.” See 42 U.S.C. § 12112(d)(4)(A). This is because monitoring compliance with the regimen necessarily requires inquiry into the “nature or severity” of the patients’ morbid obesity.

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87. Similarly, the requirement that patients provide proof from a doctor's office of their weight or BMI for the each of the past five years also presents an unreasonable barrier to the morbidly obese. It is unreasonable to demand that a morbidly patient must have documented his or her weight and BMI in each of the five preceding years before he or she can be approved for treatment.

88. Indeed, on information and belief, Defendants were fully aware that the overwhelming majority of Plaintiffs' patients were morbidly obese, and that, more likely than not, these patients had come to Plaintiffs seeking treatment for their disability. Nonetheless, in violation of the ADA and FEHA, Defendants elected to apply these heightened and unreasonable tests to Plaintiffs' patients – even though Plaintiffs are informed and believed that other beneficiaries and participants of the plans administered by United were not subjected to this heightened level of scrutiny.

2. **Defendants Imposed Scientifically Unjustified Requirements on Morbidly Obese Patients Prior to Surgery**

89. Numerous of scientific studies and formal reviews of the scientific literature have found that insurance-mandated weight loss and diet plans of the sort imposed by Defendants, through United, fail to improve patient outcomes and are less effective than bariatric surgery alone.

90. For instance, a 2011 study published in the peer-reviewed journal Surgery for Obesity and Related Diseases reviewed outcomes for 440 patients who underwent gastric surgery by the same surgeon. *See* Kuwada TS, Richardson S, El Chaar M, Norton HJ, Cleek J, Tomcho J, Stefanidis D., Insurance-mandated medical programs before bariatric surgery: do good things come to those who wait?, Surg Obes Relat Dis. 2011 Jul-Aug;7(4):526-30. The study concluded: "Patients who underwent a standardized MMP [insurance-mandated medical program] had a significant delay in their time to surgery and did not experience significant benefit in their preoperative or postoperative weight loss. Insurance companies should abandon the policy of mandating preoperative medical weight loss programs."

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91. Likewise, a 2012 meta-analysis of the scientific literature on pre-surgery weight loss programs required by insurance companies concluded that “the insurance-mandated preoperative requirements **confer no appreciable benefit** to bariatric patients. The ultimate goal of such requirements is questionable, particularly considering that no actual weight loss is required.” Ochner CN, Dambkowski CL, Yeomans BL, Teixeira J, Xavier Pi-Sunyer F, Pre-bariatric surgery weight loss requirements and the effect of preoperative weight loss on postoperative outcome, International Journal of Obesity (2012) 36, 1380-1387. The article found that requiring a preoperative plan might even be associated with “less-positive postoperative outcomes.” It also concluded that preoperative weight loss requirements would have the perverse effect of rendering patients “ineligible to receive a surgical procedure that would have likely improved their health and quality of life.” Even if enforcing such a policy might have some small benefit to *some* patients, it might be still “unethical” because it would “exclude otherwise eligible candidates from a beneficial surgical procedure in the hopes of improving the postoperative outcomes of others.”

92. Other sources are in accord. For instance, on March 23, 2011, the American Society for Metabolic & Bariatric Surgery (ASMBS), the largest and most prestigious association of bariatric surgeons, released a Position Statement on Preoperative Supervised Weight Loss Requirements which also reviewed the scientific literature and came to similar conclusions. The scientific evidence, it concluded, simply does not show that preoperative diet and weight loss programs have any effect: “[t]here are no Class I large, adequately powered randomized, prospective trials or meta-analyses to validate the hypothesis that preoperative diet attempts improve bariatric surgery outcomes.” ASMBS Position Statement at 5.<sup>4</sup> Based on its review of the literature, the ASMBS concluded that it is “inappropriate, capricious, and counter-productive given the **complete absence of a reasonable level of medical evidence to support such practice.**” *Id.* at 6.

<sup>4</sup> At the time of filing of this Complaint, this document was available at: <http://asmbs.org/2012/01/preoperative-supervised-weight-loss-requirements/>.

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93. Likewise, California's Department of Managed Health Care recently commissioned its own review of the literature on this subject, and concluded quite bluntly that "[m]andated weight loss prior to indicated bariatric surgery is without evidence-based support." Department of Managed Health Care, Review of Weight Loss Prior to Bariatric Surgery, at 2.<sup>5</sup> The DMHC found that the practice was "not medically necessary" and that [t]he risks of delaying bariatric surgery... are real and can be measured." *Id.*

94. Nor is there any doubt that the benefits of bariatric surgery for morbidly obese individuals are also real, measurable, and significant. A 2004 meta-analysis published in the prestigious Journal of the American Medical Association, for instance, concluded that "bariatric surgery in morbidly obese individuals reverses, eliminates, or significantly ameliorates diabetes, hyperlipidemia, hypertension, and obstructive sleep apnea. These benefits occur in the majority of patients who undergo surgery." Henry Buchwald, Yoav Avidor, Eugene Braunwald, et al., Bariatric Surgery: A Systematic Review and Meta-analysis, JAMA, 2004; 292(14):1724-1737. Conversely, "diet therapy, with and without support organizations, is relatively ineffective in treating obesity in the long term." *Id.* In addition, "there are currently no truly effective pharmaceutical agents to treat obesity, especially morbid obesity."

95. At least two other studies have found similar results. One is the long-term, Swedish Obese Subjects Study, a longitudinal study which tracks 2,000 subjects who underwent Lap-Band surgery and other kinds of bariatric surgery, along with 2,000 contemporaneously matched obese control subjects receiving usual care, and is still ongoing. L. Sjöström, Review of the key results from the Swedish Obese Subjects (SOS) trial – a prospective controlled intervention study of bariatric surgery, J Intern Med 2013; 273: 219–234. This study is in agreement with the results of the JAMA meta-analysis, and in particular, concludes that current drug-only treatments are insufficient and that "[u]ntil more efficient antiobesity drugs are available, surgical treatment of obesity must be more universally accessible." Results from 2004 to

<sup>5</sup> At the time of filing of this Complaint, this document was available at:  
<http://www.hmohelp.ca.gov/aboutthedmhc/org/boards/cap/BariatricREV.pdf>

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2012 from the SOS study have demonstrated that “maintained effects on risk factors over 10 years require 10%–30% maintained weight loss.”<sup>6</sup> The SOS concluded that “Surgery is the only treatment for obesity resulting in an average of more than 15% documented weight loss over 10 years.” Id at 8. Similar to the JAMA analysis, a 2010 review of roughly eight hundred patients in a single Wisconsin hospital during a seven-year span who had either received bariatric surgery, or been denied such surgery by their insurance companies found that those denied obesity surgery had strongly increased incidence of hypertension, diabetes, sleep apnea, and acid reflux, among other disorders. Harakeh A, Burkhamer K, Kallies K, Mathiason M, Kothari S, Natural history and metabolic consequences of morbid obesity for patients denied coverage for bariatric surgery. Surgery for Obesity and Related Diseases 6 (2010) 591–596.

**3. Defendants’ Conduct is a Subterfuge for Discrimination.**

96. The overwhelming scientific evidence drives home the reality that Defendants’ denial of the Lap-Band procedure to morbidly obese individuals is outright discrimination which has nothing to do with underwriting risks. Instead, Defendants’ conduct has everything to do with denying benefits to which those individuals were rightfully entitled. Thus, Defendants’ denials, in addition to being a breach of their fiduciary duties to the plans, were nothing more than subterfuge in order to circumvent the policy goals of the ADA and FEHA and discriminate against individuals who participated in various employer-sponsored health benefit plans or other plans that offered both out-of-network benefits and coverage for bariatric surgery. See 42 U.S.C. § 12201(c).

97. Plaintiffs are also informed and believe that in certain situations, Defendants denied payment for bariatric surgery and related services based upon the purported terms of the patient’s benefit plan, which Defendants represented did not cover bariatric surgery, such as the Lap-Band surgery or other procedures. To the extent that the applicable benefit plans themselves in fact

<sup>6</sup> At the time of filing of this Complaint, this document was available at: <http://onlinelibrary.wiley.com/doi/10.1111/joim.12012/pdf>.

1 denied coverage for the treatment of obesity, including Lap-Band surgery, however, the design of  
2 those plans themselves was discriminatory and violated the ADA and FEHA.

3 98. Moreover, to the extent that the applicable benefit plans themselves in fact denied  
4 coverage, Defendants failed to make any reasonable accommodation for morbidly obese patients  
5 under these plans, and failed to have any discussions with the affected individuals and/or with any  
6 plan sponsors or employers about making such accommodations. Defendants are thus, at the very  
7 least, guilty of aiding and abetting the violation of the ADA and FEHA in this respect.

8 **4. Plaintiffs Have Suffered Injury In Fact.**

9 99. As a result of Defendants' violations of FEHA and the ADA, Plaintiffs have  
10 suffered injury in fact, because the potential patients who came to them seeking Lap-Band surgery  
11 for their disability were directly or indirectly denied that opportunity as a result of Defendants'  
12 discrimination. Likewise, Plaintiffs have lost money and/or property as a result of Defendants'  
13 denials as alleged above. Indeed, Defendants' outright refusal to pay any claim submitted by any  
14 of the Plaintiffs has impaired their ability to carry out their business affairs, to the point that  
15 Plaintiffs may be forced to close their doors and cease providing needed medical services to their  
16 morbidly obese patient population.

17 100. The Defendants have unlawfully shifted the full liability of payment for medical  
18 services rendered onto the patients, who have been billed for those services. Defendants' unlawful  
19 denial of benefits for those services thereby results in injury in-fact to both the patients and to the  
20 Plaintiffs.

21 101. Moreover, Defendants' denials for the various professional and facility claims at  
22 issue in this case has interfered with Plaintiffs' physician-patient relationships and the ability of  
23 physicians to care for their patients, such as those needing follow-up appointments for adjustments  
24 to their Lap-Band (which are necessary after the band is implanted). Defendants' conduct resulted  
25 in injuries to its insureds' safety and wellbeing and violated their rights to "security" and "peace of  
26 mind," which are protected rights for those who maintain insurance. Defendants' persistent  
27 discrimination and failure to pay benefits injured Plaintiffs because it made it impossible for the  
28 patients to receive weight loss treatment at Plaintiff's facilities, violated the ADA and FEHA, and

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constituted unfair competition against Plaintiffs. Defendants' actions also inflict injury on both its insureds and Plaintiffs because they violate fiduciary responsibilities to the beneficiaries in both their role as an insurer and a third party administrator.

**F. Example Patient Claims**

102. The following examples amply illustrate why Plaintiffs' claims must be deemed exhausted and that substantive remedies are warranted. They illustrate the consistency with which United raises, in each example, disingenuous grounds for denial manufactured by United, as well as the ineffectiveness of Plaintiffs' appeals. (To comply with rules regarding protected health information and patient confidentiality, patients' actual names have not been used. A list of all the patient claims at issue will be provided to United.)

**Patient A**

103. Patient A, a female who has had a history of over five years of morbid obesity, came to Plaintiffs for a cholecystectomy (surgical removal of the gallbladder) on June 3, 2010 in preparation for receiving Lap-Band surgery. In December 2010, United issued an EOB to Plaintiffs stating that the claim could not be processed because "one or more of the following items are missing. History and physical; findings of examination; lab, radiology, pathology, and anesthesia test results; consult reports; operative/procedure report; daily progress / treatment / medication notes; physician orders for DME [Durable Medical Equipment] along with copy of invoice and delivery statement." The EOB also stated that "we cannot pay this claim because we are unable to verify state licensure of a facility or criteria to support the provider billing time. Proof of facility licensure or hospital affiliation is required."

104. In fact, however, many of the categories of documents that United demanded, such as physician orders for DME, were completely irrelevant to the surgical services provided and did not exist. The request for proof of facility licensure was similarly pretextual, as the identity of the Plaintiffs' facilities was already known to United.

105. After making a follow-up call, Plaintiffs sent all relevant medical records to United the following month. Plaintiffs also provided United with the relevant W-9 forms in response to the request for proof of facility licensure.

1 106. However, United referred the claim to Ingenix for further review, incurring  
 2 additional delay. Ingenix continued to request medical records, even though records had already  
 3 been sent. Plaintiffs' claims were ultimately denied by United in an EOB dated December 2011  
 4 due to a purported failure to provide medical records.

5 107. United subsequently denied Plaintiffs' appeal only a few months later on the  
 6 grounds that it was untimely, even though the appeal was not, in fact, untimely. Thus, to this day,  
 7 United has failed to pay Plaintiffs for its professional and facility charges for valuable medical  
 8 services that Plaintiffs provided to Patient A.

9 **Patient B**

10 108. Patient B is a morbidly obese female who came to Plaintiffs for Lap-Band surgery.  
 11 United authorized various pre-operative tests and procedures for Patient B, including cystoscopy,  
 12 ultrasounds, esophagogastroduodenoscopy ("EGD"), and polysomnography. These procedures  
 13 were performed between June and November 2011. To date, United has not paid the claims and  
 14 has not even issued Explanations of Benefits ("EOBs") for all the claims.

15 109. For instance, on June 6, 2011, Plaintiffs performed an EGD for Patient B. United  
 16 refused to pay anything relating to this procedure, including the doctor for performing the  
 17 procedure; the anesthesiologist for anesthesia services provided during the procedure; or for the  
 18 use of Plaintiffs' surgical facilities. Plaintiffs billed these claims with the medical reports to  
 19 United via certified mail. United did not pay Plaintiffs' claims. Plaintiffs called United repeatedly  
 20 to find out about the status of each the claim, including as late as April and August 2012. Though  
 21 United confirmed that they had received Plaintiffs' claims and that Plaintiffs had provided medical  
 22 records, United claimed that the claims were still being processed because additional medical  
 23 records were still needed. United subsequently denied them claims due to the purported failure to  
 24 provide medical records. However, other claims submitted by Plaintiffs in connection with Patient  
 25 B were referred to Defendant OptumInsight for further review; and to this day, United refuses to  
 26 admit or deny these claims.

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**Patient C**

110. Patient C, a morbidly obese female, received various medical services, including ultrasound, polysomnography, and an EGD with biopsies, at the facilities of Plaintiff San Diego Ambulatory Surgery Center in early 2011. Immediately after Plaintiffs submitted their claims for reimbursement, their claims were forwarded to Ingenix for "further review." The United Defendants requested, and Plaintiffs provided, medical records and further information about the claims. Some of Plaintiffs' claims regarding the services provided to Patient C were subsequently denied for a variety of pretextual reasons, including the purported failure to provide medical records and/or the purported failure to provide provider W-9 forms. Other of Plaintiffs' claims remained pending due to the purported failure to provide medical records. In addition, United received, and ignored, multiple appeal letters regarding Plaintiffs' claims. Plaintiffs have called United numerous times to request the status of payment, and United has repeatedly stated that the claims are pending or in review.

**FIRST CAUSE OF ACTION**  
**(For Unfair Business Practices in Violation of California Business & Professions Code §§ 17200 et seq.)**

111. Plaintiffs incorporate the prior paragraphs as though fully set forth herein.

112. The Unfair Competition Law ("UCL") prohibits "unfair competition," which is defined by California Business & Professions Code Section 17200 as including "any unlawful, unfair or fraudulent business act or practice ...."

113. The United Defendants have engaged in a pattern of unfair, unlawful and/or fraudulent business acts and practices against Plaintiffs as set forth below:

a. The United Defendants have illegally discriminated against patients in the provision of fringe employment benefits on the protected basis of those members' morbid obesity, in violation of the Americans with Disabilities Act, 42 U.S.C. § 12111 et seq.

b. The United Defendants have illegally discriminated against patients in the provision of fringe employment benefits on the protected basis of those members' morbid obesity,

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1 in violation of the California Fair Employment and Housing Act ("FEHA"), Cal. Gov't Code  
 2 § 12900 et seq.

3 c. The United Defendants used arbitrary, capricious and improper methods to  
 4 improperly deny or underpay Plaintiffs' claims.

5 d. The United Defendants routinely misrepresented that Plaintiffs' claims  
 6 would be paid, when in fact Defendants had no intention of paying any of Plaintiffs' claims.

7 e. The United Defendants routinely requested medical records and provider  
 8 documentation that had already been provided and were not necessary to adjudicate Plaintiffs'  
 9 claims, as a way to delay adjudication of the claims.

10 f. The United Defendants routinely referred Plaintiffs' claims to Defendant  
 11 Ingenix/OptumInsight for so-called "review."

12 g. The United Defendants routinely denied Plaintiffs' claims based on flimsy  
 13 procedural rationales, including that medical records had not been provided or that a provider was  
 14 not "recognized," that were not grounded in the terms or the language of the insurance plan.

15 h. For those health plans governed by the DMHC, the United Defendants  
 16 engaged in an "unfair payment pattern" in violation of California Health & Safety Code  
 17 § 1371.37, including but not limited, to a demonstrable and unjust pattern of reviewing and  
 18 processing complete and accurate claims that resulted in payment delays; repeated and improper  
 19 requests for medical records that are not reasonably relevant or reasonably necessary to determine  
 20 payor liability; reducing the amount of payment and/or denying payment of claims without  
 21 justification; and/or failing on a repeated basis to pay the uncontested portions of a claim within  
 22 the timeframes specified in Health & Safety Code § 1371 *et seq.*

23 i. For those health plans governed by the DMHC, the United Defendants  
 24 failed to correctly and accurately apply the criteria used to calculate UCR rates as set forth in Title  
 25 28 of the California Code of Regulations ("CCR"), section 1300.71(a)(3)(B), and failed to comply  
 26 with Health & Safety Code § 1371 and 28 CCR § 1300.71.

27 j. For those health plans governed by the DMHC, the United Defendants  
 28 illegally received compensation tied to the denial and/or reduction of amounts due on Plaintiffs'

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1 claims in willful violation of Health & Safety Code § 1399.56 (which is a misdemeanor pursuant  
 2 to Health and Safety Code § 1390).

3 k. For those health plans governed by the DMHC, the United Defendants  
 4 illegally received compensation tied to the denial and/or reduction of amounts due on Plaintiffs'  
 5 claims, in violation of Insurance Code § 796.02.

6 l. The United Defendants interfered with Plaintiffs' contracts with Third Party  
 7 Payors, including Multiplan and Three Rivers.

8 q. The United Defendants made materially false statements and used  
 9 materially false documents in connection with the payment for health care benefits, items, or  
 10 services involving a health care benefit program, as detailed in the complaint, at least tens of  
 11 thousands of times, in violation of 18 U.S.C. § 1035. Pursuant to 18 U.S.C. § 24(b), the definition  
 12 of "health care benefit program" includes Plaintiffs, as providers to whom payment may be made  
 13 for medical services under private plans affecting commerce.

14 r. The United Defendants knowingly and willfully engaged in a scheme to  
 15 defraud "health care benefit programs" and to obtain, by means of false or fraudulent pretenses,  
 16 representations, or promises, money or property owned by, or under the custody or control of,  
 17 health care benefit programs, in violation of 18 U.S.C. § 1347. Pursuant to 18 U.S.C. § 24(b), the  
 18 definition of "health care benefit program" includes Plaintiffs, as providers to whom payment may  
 19 be made for medical services under private plans affecting commerce.

20 s. With respect to health insurance plans promulgated by the United  
 21 Defendants that are subject to the California Insurance Code and/or regulated by the Department  
 22 of Insurance, the United Defendants engaged in acts of unfair competition under at least California  
 23 Insurance Code § 790.03(h), subsections, (1), (2), (3), (4), (5), (6), and (13) by, among other  
 24 things:

- 25 • misrepresenting to Plaintiffs and plan beneficiaries that United would pay the
- 26 providers' reasonable and customary charges;
- 27 • failing to respond to claim-related inquiries and communications by Plaintiffs
- 28 in a reasonably prompt manner;

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- failing to affirm or deny Plaintiffs' claims for reimbursement within a reasonable time after all proof of loss requirements had been submitted and liability had become reasonably clear;
- failing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies, and instead, illegitimately referring claims to Defendant Ingenix/OptumInsight, Inc. for further review;
- delaying the investigation and/or payment of claims by requiring the repeated submission of medical records and other documents showing entitlement to payment;
- failing to provide promptly a reasonable explanation of the basis relied upon for the denial of Plaintiffs' claims; and
- compelling insureds (and Plaintiffs, acting on behalf of such insureds) to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by the insureds, when the insureds have made claims for amounts reasonably similar to the amounts ultimately recovered.

114. The conduct alleged violates the UCL. As a result of their business acts and practices in violation of the UCL, Defendants have received and retained and continue to receive and retain monies that rightfully belong to Plaintiffs as compensation for rendering covered, medically necessary services to plan members. Plaintiffs have thus suffered "injury in fact" because Defendants have unlawfully, unfairly, and fraudulently withheld monies from Plaintiffs to which Plaintiffs were entitled as compensation for rendering covered, medically necessary services to plan participants and beneficiaries.

115. Plaintiffs have further suffered "injury in fact" because Defendants obstructed and discriminated against morbidly obese individuals seeking weight loss surgery at Plaintiffs' clinics, thereby both depriving morbidly obese individuals from the benefits of such advantageous and medically necessary surgery *and* harming Plaintiffs' business interests.

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116. Defendants' conduct in violation of the UCL is likely to continue absent judicial intervention. This conduct threatens not only Plaintiffs' economic well-being and future viability, but also the health of the public and the needs of morbidly obese individuals in California.

117. Business & Professions Code § 17203 provides that any court of competent jurisdiction may enjoin any person from engaging in unfair competition and restore to any person who is a victim of that unfair competition any money acquired thereby. Plaintiffs seek restitution of an amount to be proved at trial, plus applicable statutory interest, which is the amount that the Defendants are obligated to pay Plaintiffs for the services Plaintiffs provided to plan participants and beneficiaries. Plaintiffs further seek an injunction prohibiting Defendants' ongoing conduct in using inappropriate methodologies to deny or underpay Plaintiffs' claims for medical treatment provided to plan members. Furthermore, the injunction should force Defendants to correctly price past and future claims by Plaintiffs by determining UCR based on appropriate UCR data.

118. Plaintiffs' legal remedies are inadequate in that Defendants' unlawful, unfair, and fraudulent conduct is ongoing and repeated litigation to correct Defendants' ongoing actions would be inefficient for the parties and the Court. Plaintiffs' damages cannot be fully compensated by money and are difficult or impossible to ascertain in terms of money alone. The loss of revenue from Defendants' illegal and unfair withholding of claim payments is severely impeding Plaintiffs' ability to provide adequate care for patients.

## **SECOND CAUSE OF ACTION**

### **(For Breach of Implied-In-Fact Contract – Authorized Services/No Authorization Needed Services)**

119. Plaintiffs incorporate the prior paragraphs as though fully set forth herein.

120. Plaintiffs and Defendants entered into implied-in-fact contracts through Defendants' course of conduct (i) for services that were authorized by the Defendants, and (ii) for services for which United told the Plaintiffs that no authorization was needed, whereby Plaintiffs then provided the services to the patients, and the Defendants agreed to pay for such services.

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121. This course of conduct created implied-in-fact contracts whereby Plaintiffs agreed to provide, and Defendants agreed to pay, for medical services rendered to members and insureds of insurance plans administered and/or funded by United.

122. For each of the claims at issue, Plaintiffs confirmed that the patient was an eligible member of one of the Defendants' plans by contacting United, typically by telephone. When Plaintiffs called Defendants, they also inquired as to which services required prior authorization by United, and which services did not require such authorization.

123. When the Plaintiff providers called United for insurance verification purposes, they also asked United whether United would pay the Providers' reasonable and customary fees. In virtually every instance, the United representative responded that they would pay the reasonable and customary fees charged by the Plaintiffs for their services.

124. At the time when Plaintiffs called United for insurance verification purposes, Plaintiffs made notes of those calls in a database and/or computer system maintained by Plaintiffs. Plaintiffs' notes reflect whether United represented during the call that benefits existed for a given medical service, and whether authorization was necessary. Plaintiffs are informed and believe that United maintained similar notes.

125. For medical services that United indicated required an authorization, Plaintiffs sought, and received, such authorization from United before providing such services to the patient. For medical services not requiring an authorization, Plaintiffs relied on United's representation to Plaintiffs during the initial verification phone call that no explicit authorization was required for Plaintiffs to provide the services to United's members.

126. Either way, Plaintiffs relied upon United's representations that the services were explicitly authorized or did not require authorization, and United's representations that it would pay Plaintiffs' reasonable and customary fees, when Plaintiffs provided medical services to patients. In no instance did the Plaintiffs expect that they would provide their medical services to members and insureds of United for free or at reduced rates. Rather, they expected their reasonable and customary fees to be paid as verified by United.

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127. Plaintiffs are informed and believe that United maintains records of all authorizations for medical services in its computer systems and/or databases.

128. Having authorized services, or having confirmed that no authorization was needed, and having represented that they would pay Plaintiffs' reasonable and customary charges, Defendants thereby agreed to pay the Plaintiffs at the reasonable and customary charges.

129. If Defendants did not intend to pay Plaintiffs, they could have withheld authorization for particular services. Defendants also could have informed Plaintiffs during the initial verification of insurance that they did not intend to pay any of the claims submitted by Plaintiff in connection with the services rendered. Defendants failed to do so, however.

Therefore, Defendants entered into implied-in-fact contracts with the Plaintiffs to pay Plaintiffs' reasonable and customary charges.

130. At all relevant times, Plaintiffs were not under contract with United, and therefore were never obligated to accept less than their full billed charges. Certainly, Plaintiffs were not obligated to provide their services for free.

131. Plaintiffs have performed all of the obligations required of them under the implied-in-fact contracts with the defendants for the authorized services.

132. Each of the Defendants breached the terms of each of the implied-in-fact contracts by refusing to pay the Plaintiffs for the services according to the terms of the implied-in-fact contracts. The breaches also included, among other things, making material misrepresentations regarding status of Plaintiffs' claims; making unjustified requests for medical records and provider documentation in order to delay the processing of Plaintiffs' claims; subjecting Plaintiffs' claims to an unwarranted, fraudulent and pretextual level of scrutiny by Defendant Optum/Ingenix; denying claims and appeals without justification; and providing an arbitrary and capricious benefit determination and appeal process.

133. As a direct and proximate result of United's breaches of these implied-in-fact contracts, Plaintiffs have been damaged in an amount to be proven at trial, plus applicable statutory interest.

**THIRD CAUSE OF ACTION**

**(For Equitable Estoppel)**

134. Plaintiffs incorporate the prior paragraphs as though fully set forth herein.

135. United was apprised of the facts concerning Plaintiffs' request to provide services to United's members. When Plaintiffs called United for insurance verification purposes, they asked whether United whether out-of-network benefits were available under the terms of the patients' plans for the medical services that Plaintiff intended to perform. In virtually every instance, United's representatives responded that they were.

136. During these calls, Plaintiffs further inquired whether United would pay the Plaintiff Providers' usual and customary charges. Again, in virtually every instance, the United representative responded that they would pay the usual and customary fees charged by the Plaintiff providers for the services specified.

137. Furthermore, for medical services that United indicated required an authorization, Plaintiffs sought, and received, such authorization from United before providing such services to the patient. For medical services not requiring an authorization, Plaintiffs relied on United's representation to Plaintiffs during the initial verification phone call that no explicit authorization was required for Plaintiffs to provide the services to United's members. In providing these responses, United intended that its conduct would be acted upon by Plaintiffs, and/or knew that, after informing Plaintiffs that the services were authorized, or that no authorization was necessary, that Plaintiffs would provide the discussed services to United's members.

138. Defendants intended that Plaintiffs rely upon the representations described above. It is common practice in the trade of the health care industry for plans to make these statements to tell providers that the providers will get paid for services to the members of the plans.

139. The language of the plans pertaining to benefits for out-of-network surgery either clearly provided that those benefits would be paid at a UCR rate, or if they did not, the terms of the plan were ambiguous.

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140. Plaintiffs were ignorant that United never intended to reimburse Plaintiffs for the services they provided to United's members. Plaintiffs were ignorant that United would create pretextual reasons for refusing to process or to pay the claims.

141. Plaintiffs reasonably and actually relied on the statements by the United Defendants that the services were authorized, or that no authorization was needed.

142. Plaintiff likewise reasonably and actually relied on the statements by the United Defendants that out-of-network surgical benefits were available under the terms of the plans and that the Defendants would pay Plaintiffs' reasonable and customary charges. In reliance on these representations, Plaintiffs rendered medical services to the patients, and did not seek potential avenues of payment other than from the United Defendants.

143. Accordingly, Defendants are estopped from contending that the services it authorized are not payable due to lack of authorization, and are estopped from refusing to pay the reasonable and customary value for these services.

#### **FOURTH CAUSE OF ACTION**

#### **(For Recovery for Services Rendered)**

144. Plaintiffs incorporate the prior paragraphs as though fully set forth herein.

145. To the extent the causes of action alleged above for any reason do not apply to the services at issue, Plaintiffs allege in the alternative that Defendants are indebted to Plaintiffs at the quantum meruit rate for the services rendered by Plaintiffs to the members and insureds of health plans administered and/or funded by Defendants.

146. Plaintiffs provided medically necessary treatment to each of the members who received health care services from Plaintiffs. By authorizing the Plaintiffs to provide health care services to the members, by verifying the members' coverage under the Health Plan, by misrepresenting, concealing and/or failing to disclose United's intent not to pay Plaintiffs for their services, and by other words and/or conduct, Defendants, on their own behalf and/or as the agent of one or more of the other Defendants, requested that Plaintiffs provide those services.

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147. Defendants received, accepted, used, enjoyed and benefited from Plaintiffs' valuable health care services. Defendants knew that the services were being provided to the members for the benefit of Defendants, and Defendants promised to pay Plaintiffs for those services.

148. As a result, each of the Defendants became indebted to Plaintiffs for the health care services rendered by Plaintiffs to the members.

149. Each of the Defendants has failed and refused, and continues to refuse, to timely and properly pay Plaintiffs for the reasonable and customary fair market value of the services Plaintiffs provided to the members. Instead, Defendants have decided to delay payment, deny payment, or pay whatever amount they arbitrarily, capriciously, and unilaterally decided was appropriate for such services, at rates far below the services' reasonable and customary fair market value.

150. The reasonable and customary fair market value of the services provided by Plaintiffs to the members for the benefit of Defendants is Plaintiffs' billed charges for the services.

151. Plaintiffs have demanded, on numerous occasions, that the Defendants pay for the health care services Plaintiffs has provided to the members, and has objected to the failure to timely and properly pay Plaintiffs for the services provided to the members.

152. Accordingly, there is now due, owing and unpaid from the Defendants to Plaintiffs an amount to be proven at trial, plus applicable statutory interest.

#### **FIFTH CAUSE OF ACTION**

#### **(For Declaratory Relief)**

153. Plaintiffs incorporate the prior paragraphs as though fully set forth herein.

154. A controversy has arisen between each of the Defendants and Plaintiffs as to Plaintiffs' right to be afforded access to an honest and unbiased claims administration process, and to be paid under the terms of the benefits plans at issue.

155. Accordingly, Plaintiffs seek a declaration that:

a. Defendants' use of the various procedural pretexts described above that are being used to delay and/or deny payment on Plaintiffs' claims, such as repeated requests for

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 1875 CENTURY PARK EAST, SUITE 1600  
 LOS ANGELES, CALIFORNIA 90067-2517  
 TEL: (310) 551-8111 • FAX: (310) 551-8181

1 medical records and constant referrals to Ingenix for further review, are arbitrary and capricious,  
 2 and a violation of California law concerning prompt payment of claims;

3 b. Defendants are now barred from relying upon any rationales for denying  
 4 Plaintiffs' claims that Defendants did not raise during the administrative process and prior to  
 5 litigation;

6 c. Defendants must immediately cease the use of such procedural pretexts;

7 d. Defendants are required timely re-process all claims that have been  
 8 submitted by the Plaintiffs since United first began its campaign to deny payments to the  
 9 Plaintiffs, and to pay those claims pursuant to the terms of the Plans;

10 e. Defendants must conduct a "full and fair review" for all claims being re-  
 11 processed, free of dishonest and surreptitious delay and denial tactics;

12 f. Defendants must render timely benefit decisions on all future claims  
 13 submitted by Plaintiffs in accordance with all applicable rules and regulations governing the time  
 14 in which such decisions must be rendered;

15 g. Defendants must promptly and timely provide Explanation of Benefits and  
 16 responses to appeals;

17 h. When denying Plaintiffs' claims, Defendants must disclose with specificity  
 18 the reasons for the adverse determinations, and cite the specific provisions of the plans that  
 19 support the determinations;

20  
 21 **WHEREFORE**, Plaintiffs pray for and demand judgment against the Defendants as set  
 22 forth above and as follows:

23 1. An injunction prohibiting Defendants from engaging in the unfair business  
 24 practices complained of, and requiring Defendants to restore to Plaintiffs, and otherwise to  
 25 disgorge, any money that has been acquired from Plaintiffs, by means of the unfair business  
 26 practices being committed by Defendants.

27 2. The reasonable and customary value of the medical services provided by Plaintiffs  
 28 to Defendants' insureds and members.

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3. For actual damages in an amount according to proof at trial.

4. For a judicial declaration that:

a. Defendants' use of the various procedural pretexts described above that are being used to delay and/or deny payment on Plaintiffs' claims, such as repeated requests for medical records and constant referrals to Ingenix for further review, are arbitrary and capricious;

b. Defendants are now barred from relying upon any rationales for denying Plaintiffs' claims that Defendants did not raise during the administrative process and prior to litigation;

c. Defendants must immediately cease the use of such procedural pretexts;

d. Defendants are required timely re-process all claims that have been submitted by the Plaintiffs since United first began its campaign to deny payments to the Plaintiffs, and to pay those claims pursuant to the terms of the Plans;

e. Defendants must conduct a "full and fair review" for all claims being re-processed, free of dishonest and surreptitious delay and denial tactics;

f. Defendants must render timely benefit decisions on all future claims submitted by Plaintiffs in accordance with all applicable rules and regulations governing the time in which such decisions must be rendered;

g. Defendants must promptly and timely provide Explanation of Benefits and responses to appeals;

h. When denying Plaintiffs' claims, Defendants must disclose with specificity the reasons for the adverse determinations, and cite the specific provisions of the plans that support the determinations;

5. Awarding prejudgment interest and costs; and

6. Awarding such other relief as the Court deems just and proper.

DATED: March 21, 2014

HOOPER, LUNDY & BOOKMAN, P.C.

By: 

DARON L. TOOCH

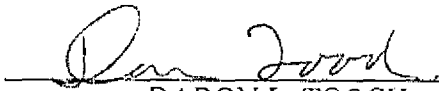
Attorneys for Plaintiffs

DEMAND FOR JURY TRIAL

Plaintiffs demand a jury trial for all claims so triable.

DATED: March 21, 2014

HOOPER, LUNDY & BOOKMAN, P.C.

By:   
DARON L. TOOCH  
Attorneys for Plaintiffs

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## VOLUNTARY EFFICIENT LITIGATION STIPULATIONS

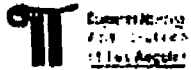


Superior Court of California  
County of Los Angeles



Los Angeles County  
Bar Association  
Litigation Section

Los Angeles County  
Bar Association Labor and  
Employment Law Section



Consumer Attorneys  
Association of Los Angeles



Southern California  
Defense Counsel



Association of  
Business Trial Lawyers



California Employment  
Lawyers Association

The Early Organizational Meeting Stipulation, Discovery Resolution Stipulation, and Motions in Limine Stipulation are voluntary stipulations entered into by the parties. The parties may enter into one, two, or all three of the stipulations; however, they may not alter the stipulations as written, because the Court wants to ensure uniformity of application. These stipulations are meant to encourage cooperation between the parties and to assist in resolving issues in a manner that promotes economic case resolution and judicial efficiency.

*The following organizations endorse the goal of promoting efficiency in litigation and ask that counsel consider using these stipulations as a voluntary way to promote communications and procedures among counsel and with the court to fairly resolve issues in their cases.*

◆ Los Angeles County Bar Association Litigation Section ◆

◆ Los Angeles County Bar Association  
Labor and Employment Law Section ◆

◆ Consumer Attorneys Association of Los Angeles ◆

◆ Southern California Defense Counsel ◆

◆ Association of Business Trial Lawyers ◆

◆ California Employment Lawyers Association ◆

NAME AND ADDRESS OF ATTORNEY OR PARTY WITHOUT ATTORNEY		STATE BAR NUMBER	Reserved for Court's File Stamp
TELEPHONE NO.:		FAX NO. (Optional):	
E-MAIL ADDRESS (Optional):			
ATTORNEY FOR:			
SUPERIOR COURT OF CALIFORNIA, COUNTY OF LOS ANGELES			
COURTHOUSE ADDRESS:			
PLAINTIFF:			
DEFENDANT:			
STIPULATION – EARLY ORGANIZATIONAL MEETING		CASE NUMBER:	

This stipulation is intended to encourage cooperation among the parties at an early stage in the litigation and to assist the parties in efficient case resolution.

The parties agree that:

1. The parties commit to conduct an initial conference (in-person or via teleconference or via videoconference) within 15 days from the date this stipulation is signed, to discuss and consider whether there can be agreement on the following:
  - a. Are motions to challenge the pleadings necessary? If the issue can be resolved by amendment as of right, or if the Court would allow leave to amend, could an amended complaint resolve most or all of the issues a demurrer might otherwise raise? If so, the parties agree to work through pleading issues so that a demurrer need only raise issues they cannot resolve. Is the issue that the defendant seeks to raise amenable to resolution on demurrer, or would some other type of motion be preferable? Could a voluntary targeted exchange of documents or information by any party cure an uncertainty in the pleadings?
  - b. Initial mutual exchanges of documents at the "core" of the litigation. (For example, in an employment case, the employment records, personnel file and documents relating to the conduct in question could be considered "core." In a personal injury case, an incident or police report, medical records, and repair or maintenance records could be considered "core.");
  - c. Exchange of names and contact information of witnesses;
  - d. Any insurance agreement that may be available to satisfy part or all of a judgment, or to indemnify or reimburse for payments made to satisfy a judgment;
  - e. Exchange of any other information that might be helpful to facilitate understanding, handling, or resolution of the case in a manner that preserves objections or privileges by agreement;
  - f. Controlling issues of law that, if resolved early, will promote efficiency and economy in other phases of the case. Also, when and how such issues can be presented to the Court;
  - g. Whether or when the case should be scheduled with a settlement officer, what discovery or court ruling on legal issues is reasonably required to make settlement discussions meaningful, and whether the parties wish to use a sitting judge or a private mediator or other options as

EVENT TITLE  	CASE NUMBER  
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discussed in the "Alternative Dispute Resolution (ADR) Information Package" served with the complaint;

- h. Computation of damages, including documents not privileged or protected from disclosure, on which such computation is based;
  - i. Whether the case is suitable for the Expedited Jury Trial procedures (see information at [www.basuperiorcourt.org](http://www.basuperiorcourt.org) under "Civil" and then under "General Information").
2. The time for a defending party to respond to a complaint or cross-complaint will be extended to \_\_\_\_\_ for the complaint, and \_\_\_\_\_ for the cross-complaint, which is comprised of the 30 days to respond under Government Code § 88816(b), and the 30 days permitted by Code of Civil Procedure section 1054(a), good cause having been found by the Civil Supervising Judge due to the case management benefits provided by this Stipulation.
  3. The parties will prepare a joint report titled "Joint Status Report Pursuant to Initial Conference and Early Organizational Meeting Stipulation, and if desired, a proposed order summarizing results of their meet and confer and advising the Court of any way it may assist the parties' efficient conduct or resolution of the case. The parties shall attach the Joint Status Report to the Case Management Conference statement, and file the documents when the CMC statement is due.
  4. References to "days" mean calendar days, unless otherwise noted. If the date for performing any act pursuant to this stipulation falls on a Saturday, Sunday or Court holiday, then the time for performing that act shall be extended to the next Court day.

The following parties stipulate:

Date:

\_\_\_\_\_  
(TYPE OR PRINT NAME)

Date:

\_\_\_\_\_  
(TYPE OR PRINT NAME)

Date:

\_\_\_\_\_  
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(TYPE OR PRINT NAME)

Date:

\_\_\_\_\_  
(TYPE OR PRINT NAME)

> \_\_\_\_\_  
(ATTORNEY FOR PLAINTIFF)

> \_\_\_\_\_  
(ATTORNEY FOR DEFENDANT)

> \_\_\_\_\_  
(ATTORNEY FOR DEFENDANT)

> \_\_\_\_\_  
(ATTORNEY FOR DEFENDANT)

> \_\_\_\_\_  
(ATTORNEY FOR \_\_\_\_\_)

> \_\_\_\_\_  
(ATTORNEY FOR \_\_\_\_\_)

> \_\_\_\_\_  
(ATTORNEY FOR \_\_\_\_\_)

NAME AND ADDRESS OF ATTORNEY OR PARTY WITHOUT ATTORNEY:		STATE BAR NUMBER	Approved by Clerk's File Stamp
TELEPHONE NO.:		FAX NO. (Optional):	
E-MAIL ADDRESS (Optional):			
ATTORNEY FOR (Street):			
<b>SUPERIOR COURT OF CALIFORNIA, COUNTY OF LOS ANGELES</b>			
COURTHOUSE ADDRESS:			
PLAINTIFF:			
DEFENDANT:			
<b>STIPULATION - DISCOVERY RESOLUTION</b>		Clerk's Stamp	

This stipulation is intended to provide a fast and informal resolution of discovery issues through limited paperwork and an informal conference with the Court to aid in the resolution of the issues.

The parties agree that:

1. Prior to the discovery cut-off in this action, no discovery motion shall be filed or heard unless the moving party first makes a written request for an Informal Discovery Conference pursuant to the terms of this stipulation.
2. At the Informal Discovery Conference the Court will consider the dispute presented by parties and determine whether it can be resolved informally. Nothing set forth herein will preclude a party from making a record at the conclusion of an Informal Discovery Conference, either orally or in writing.
3. Following a reasonable and good faith attempt at an informal resolution of each issue to be presented, a party may request an Informal Discovery Conference pursuant to the following procedures:
  - a. The party requesting the Informal Discovery Conference will:
    - i. File a Request for Informal Discovery Conference with the clerk's office on the approved form (copy attached) and deliver a courtesy, conformed copy to the assigned department;
    - ii. Include a brief summary of the dispute and specify the relief requested; and
    - iii. Serve the opposing party pursuant to any authorized or agreed method of service that ensures that the opposing party receives the Request for Informal Discovery Conference no later than the next court day following the filing.
  - b. Any Answer to a Request for Informal Discovery Conference must:
    - i. Also be filed on the approved form (copy attached);
    - ii. Include a brief summary of why the requested relief should be denied;

SHORT TITLE:	CASE NUMBER:
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- iii. Be filed within two (2) court days of receipt of the Request; and
  - iv. Be served on the opposing party pursuant to any authorized or agreed upon method of service that ensures that the opposing party receives the Answer no later than the next court day following the filing.
- c. No other pleadings, including but not limited to exhibits, declarations, or attachments, will be accepted.
  - d. If the Court has not granted or denied the Request for Informal Discovery Conference within ten (10) days following the filing of the Request, then it shall be deemed to have been denied. If the Court acts on the Request, the parties will be notified whether the Request for Informal Discovery Conference has been granted or denied and, if granted, the date and time of the Informal Discovery Conference, which must be within twenty (20) days of the filing of the Request for Informal Discovery Conference.
  - e. If the conference is not held within twenty (20) days of the filing of the Request for Informal Discovery Conference, unless extended by agreement of the parties and the Court, then the Request for the Informal Discovery Conference shall be deemed to have been denied at that time.
- 4. If (a) the Court has denied a conference or (b) one of the time deadlines above has expired without the Court having acted or (c) the Informal Discovery Conference is concluded without resolving the dispute, then a party may file a discovery motion to address unresolved issues.
  - 5. The parties hereby further agree that the time for making a motion to compel or other discovery motion is tolled from the date of filing of the Request for Informal Discovery Conference until (a) the request is denied or deemed denied or (b) twenty (20) days after the filing of the Request for Informal Discovery Conference, whichever is earlier, unless extended by Order of the Court.
- It is the understanding and intent of the parties that this stipulation shall, for each discovery dispute to which it applies, constitute a writing memorializing a "specific later date to which the propounding [or demanding or requesting] party and the responding party have agreed in writing," within the meaning of Code Civil Procedure sections 2030.300(c), 2031.320(c), and 2033.280(c).
- 6. Nothing herein will preclude any party from applying ex parte for appropriate relief, including an order shortening time for a motion to be heard concerning discovery.
  - 7. Any party may terminate this stipulation by giving twenty-one (21) days notice of intent to terminate the stipulation.
  - 8. References to "days" mean calendar days, unless otherwise noted. If the date for performing any act pursuant to this stipulation falls on a Saturday, Sunday or Court holiday, then the time for performing that act shall be extended to the next Court day.

SHORT TITLE:	CASE NUMBER:
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The following parties stipulate:

Date:

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Date:

(TYPE OR PRINT NAME)

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(ATTORNEY FOR PLAINTIFF)

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(ATTORNEY FOR DEFENDANT)

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(ATTORNEY FOR DEFENDANT)

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(ATTORNEY FOR DEFENDANT)

>

(ATTORNEY FOR \_\_\_\_\_)

>

(ATTORNEY FOR \_\_\_\_\_)

>

(ATTORNEY FOR \_\_\_\_\_)

NAME AND ADDRESS OF ATTORNEY OR PARTY WITHOUT ATTORNEY		DECK NUMBER	Reserved for Clerk's File Stamp
TELEPHONE NO.: E-MAIL ADDRESS (Optional): ATTORNEY FOR: (Name)		FAX NO. (Optional)	
<b>SUPERIOR COURT OF CALIFORNIA, COUNTY OF LOS ANGELES</b>			
COURTHOUSE ADDRESS:			
PLAINTIFF:			
DEFENDANT:			COURTROOM
<b>INFORMAL DISCOVERY CONFERENCE</b> (pursuant to the Discovery Resolution Stipulation of the parties)			

- This document relates to:  
☐ Request for Informal Discovery Conference  
☐ Answer to Request for Informal Discovery Conference
- Deadline for Court to decide on Request: \_\_\_\_\_ (Insert date 10 calendar days following filing of the Request).
- Deadline for Court to hold Informal Discovery Conference: \_\_\_\_\_ (Insert date 28 calendar days following filing of the Request).
- For a Request for Informal Discovery Conference, briefly describe the nature of the discovery dispute, including the facts and legal arguments at issue. For an Answer to Request for Informal Discovery Conference, briefly describe why the Court should deny the requested discovery, including the facts and legal arguments at issue.

NAME AND ADDRESS OF ATTORNEY OR PARTY/WHOLE ATTORNEY:		STATE BAR NUMBER	Placed in Court's File Stamp
TELEPHONE NO.:		FAX NO. (Optional):	
E-MAIL ADDRESS (Optional):			
ATTORNEY FOR (Name):			
SUPERIOR COURT OF CALIFORNIA, COUNTY OF LOS ANGELES			
COURTHOUSE ADDRESS:			
PLAINTIFF:			
DEFENDANT:			
STIPULATION AND ORDER – MOTIONS IN LIMINE			CASE NUMBER

This stipulation is intended to provide fast and informal resolution of evidentiary issues through diligent efforts to define and discuss such issues and limit paperwork.

The parties agree that:

1. At least \_\_\_\_ days before the final status conference, each party will provide all other parties with a list containing a one paragraph explanation of each proposed motion in limine. Each one paragraph explanation must identify the substance of a single proposed motion in limine and the grounds for the proposed motion.
2. The parties thereafter will meet and confer, either in person or via teleconference or videoconference, concerning all proposed motions in limine. In that meet and confer, the parties will determine:
  - a. Whether the parties can stipulate to any of the proposed motions. If the parties so stipulate, they may file a stipulation and proposed order with the Court.
  - b. Whether any of the proposed motions can be briefed and submitted by means of a short joint statement of issues. For each motion which can be addressed by a short joint statement of issues, a short joint statement of issues must be filed with the Court 10 days prior to the final status conference. Each side's portion of the short joint statement of issues may not exceed three pages. The parties will meet and confer to agree on a date and manner for exchanging the parties' respective portions of the short joint statement of issues and the process for filing the short joint statement of issues.
3. All proposed motions in limine that are not either the subject of a stipulation or briefed via a short joint statement of issues will be briefed and filed in accordance with the California Rules of Court and the Los Angeles Superior Court Rules.

<b>ORDER TITLE</b>	<b>CASE NUMBER</b>
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**The following parties stipulate:**

**Date:**

\_\_\_\_\_  
(TYPE OR PRINT NAME)

**Date:**

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**Date:**

\_\_\_\_\_  
(TYPE OR PRINT NAME)

➤ \_\_\_\_\_  
(ATTORNEY FOR PLAINTIFF)

➤ \_\_\_\_\_  
(ATTORNEY FOR DEFENDANT)

➤ \_\_\_\_\_  
(ATTORNEY FOR DEFENDANT)

➤ \_\_\_\_\_  
(ATTORNEY FOR DEFENDANT)

➤ \_\_\_\_\_  
(ATTORNEY FOR \_\_\_\_\_)

➤ \_\_\_\_\_  
(ATTORNEY FOR \_\_\_\_\_)

➤ \_\_\_\_\_  
(ATTORNEY FOR \_\_\_\_\_)

**THE COURT SO ORDERS.**

**Date:** \_\_\_\_\_

\_\_\_\_\_  
JUDICIAL OFFICER

**COPY**

1 **LARRY A. WALRAVEN (S.B.# 143327)**  
2 **BRYAN S. WESTERFELD (S.B.# 218253)**  
3 **NICOLE E. WURSCHER (S.B.# 245879)**  
4 **WALRAVEN & WESTERFELD LLP**  
5 101 Enterprise, Suite 350  
6 Aliso Viejo, California 92656  
7 Telephone: (949) 215-1990  
8 Fax: (949) 215-1999

9 Attorneys for UnitedHealth Group, Inc.; United Healthcare  
10 Services, Inc., United Healthcare Insurance Company;  
11 OptumInsight, Inc.

**CONFORMED COPY**  
**ORIGINAL FILED**  
Superior Court Of California  
County Of Los Angeles

**APR 21 2014**

Sherri R. Carter, Executive Officer/Clerk  
By: Amber Hayes, Deputy

8 **SUPERIOR COURT OF THE STATE OF CALIFORNIA**  
9 **COUNTY OF LOS ANGELES**

10 **ALMONT AMBULATORY SURGERY**  
11 **CENTER, LLC, a California limited liability**  
12 **company; BAKERSFIELD SURGERY**  
13 **INSTITUTE, LLC, a California limited**  
14 **liability company; INDEPENDENT**  
15 **MEDICAL SERVICES, INC., a California**  
16 **corporation; MODERN INSTITUTE OF**  
17 **PLASTIC SURGERY & ANTIAGING,**  
18 **INC., a California corporation; NEW LIFE**  
19 **SURGERY CENTER, LLC, a California**  
20 **limited liability company, dba BEVERLY**  
21 **HILLS SURGERY CENTER; ORANGE**  
22 **GROVE SURGERY CENTER, LLC, a**  
23 **California limited liability company; SAN**  
24 **DIEGO AMBULATORY SURGERY**  
25 **CENTER, LLC, a California limited liability**  
26 **company; SKIN CANCER &**  
27 **RECONSTRUCTIVE SURGERY**  
28 **SPECIALISTS OF BEVERLY HILLS,**  
**INC., a California corporation VALENCIA**  
**AMBULATORY SURGERY CENTER,**  
**LLC, a California limited liability company;**  
**WEST HILLS SURGERY CENTER, LLC, a**  
**California limited liability company,**

Plaintiffs,

Case No. BC540056

**DEFENDANTS' ANSWER TO**  
**COMPLAINT**

COMPLAINT FILED: March 21, 2014

ANSWER TO COMPLAINT

1 v.

2 UNITEDHEALTH GROUP, INC.; UNITED  
3 HEALTHCARE SERVICES, INC.,  
4 UNITEDHEALTHCARE INSURANCE  
5 COMPANY; OPTUMINSIGHT, INC., and  
6 DOES I through 20

Defendants.

7 Defendants UnitedHealth Group, Inc., United Healthcare Services, Inc., United  
8 Healthcare Insurance Company, and OptumInsight, Inc. ("United" or "Defendants"), for itself  
9 and for no other defendant, answers Plaintiffs ("Plaintiffs") Complaint as follows:

10 Pursuant to the provisions of section 431.30 of the California Code of Civil Procedure, United  
11 denies each and every, all and singular, allegations of said Complaint and further denies that  
12 Plaintiff was damaged in the sum alleged or in any sum or at all.

13  
14 **AND AS FOR THEIR AFFIRMATIVE DEFENSES TO ALL CAUSES OF ACTION**  
15 **PURPORTED TO BE SET FORTH AGAINST DEFENDANTS IN THE COMPLAINT**  
16 **HEREIN, DEFENDANTS AVER AS FOLLOWS:**

17  
18 **FIRST AFFIRMATIVE DEFENSE**

19 1. Said causes of action, and each of them, fail to state facts sufficient to constitute  
20 a cause of action.

21  
22 **SECOND AFFIRMATIVE DEFENSE**

23 2. Said causes of action, and each of them, fail to state facts sufficient to constitute  
24 a cause of action as against these answering defendants.

1 **THIRD AFFIRMATIVE DEFENSE**

2 3. Said causes of action, and each of them, are barred, in whole or in part, by the  
3 statute of limitations as codified in California Code of Civil Procedure sections 337 and 339.  
4

5 **FOURTH AFFIRMATIVE DEFENSE**

6 4. Some or all of Plaintiffs' claims are completely and expressly preempted by the  
7 Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001, *et seq.*, ("ERISA").  
8

9 **FIFTH AFFIRMATIVE DEFENSE**

10 5. Said causes of action, and each of them, are barred by ERISA, in that Plaintiffs  
11 have failed to comply with the requirements of ERISA and have failed to exhaust, in whole or  
12 in part, the administrative claims procedures pursuant to ERISA.  
13

14 **SIXTH AFFIRMATIVE DEFENSE**

15 6. If Plaintiffs were entitled to recover on these claims, although such is not  
16 admitted hereby or herein, Plaintiffs' claims must be reduced in accordance with the  
17 respective limitations on the amount of benefits payable under the specific provisions of the  
18 relevant patient benefit plan(s), including but not limited to reduction of charges consistent  
19 with "eligible expenses" under the provisions of the relevant patient benefit plan(s),  
20 application of deductibles and co-payments, and application of lifetime, annual and/or per  
21 visit or per occurrence maximums under the plans.  
22

23 **SEVENTH AFFIRMATIVE DEFENSE**

24 7. Plaintiffs' claims are in the nature of benefit claims, and Defendants' actions of  
25 which Plaintiffs complain were neither arbitrary nor capricious.  
26  
27  
28

1 **EIGHTH AFFIRMATIVE DEFENSE**

2 8. Said causes of action, and each of them, are barred, in whole or in part, by the  
3 defense of unclean hands.  
4

5 **NINTH AFFIRMATIVE DEFENSE**

6 9. Said causes of action, and each of them, are barred in whole or in part by the  
7 defense of accord and satisfaction.  
8

9 **TENTH AFFIRMATIVE DEFENSE**

10 10. Said causes of action, and each of them, are barred, in whole or in part, by the  
11 defense of waiver.  
12

13 **ELEVENTH AFFIRMATIVE DEFENSE**

14 11. Said causes of action, and each of them, are barred, in whole or in part, by the  
15 defense of payment.  
16

17 **TWELFTH AFFIRMATIVE DEFENSE**

18 12. If Defendants did breach a contract with Plaintiffs, although such is not  
19 admitted hereby or herein, any failure of Defendants to perform the conditions of the contract  
20 resulted from Plaintiffs' failure to perform and such performance by Plaintiffs was a  
21 condition precedent to or concurrent with performance by Defendants.  
22

23 **THIRTEENTH AFFIRMATIVE DEFENSE**

24 13. If Defendants did breach a contract with Plaintiffs, although such is not  
25 admitted hereby or herein, any failure of Defendants to perform the conditions of the contract  
26 was excused by the Plaintiffs' breach of the terms and conditions of the contract.  
27  
28

1 **FOURTEENTH AFFIRMATIVE DEFENSE**

2 14. Defendants are informed and believe and on such basis alleges that they may  
3 have additional defenses available to them, which are not now fully known and of which they  
4 are not now aware. Defendants reserve the right to raise and assert such additional defenses  
5 once such additional defenses have been ascertained.

6  
7 **FIFTEENTH AFFIRMATIVE DEFENSE**

8 15. Plaintiffs' claims are barred for failure to mitigate damages.

9  
10 **SIXTEENTH AFFIRMATIVE DEFENSE**

11 16. Plaintiffs' claims are barred because they have failed to raise their claims within  
12 the time frame required by ERISA's statute of limitations, or the limitations periods  
13 referenced in the various plan documents.

14  
15 **SEVENTEETH AFFIRMATIVE DEFENSE**

16 17. Plaintiffs' claims are barred because they seek to recover amounts for services  
17 reimbursed that are unreasonable or not medically necessary, including, for example, claims  
18 that were wrongfully submitted, unnecessary, or claims for which Plaintiffs did not collect  
19 copays or coinsurance.

20  
21 **EIGHTEENTH AFFIRMATIVE DEFENSE**

22 18. To the extent that Plaintiffs have suffered damages, United is entitled to set off  
23 and recoupment against any such damages equal to amounts Plaintiffs owe to United (or the  
24 plans for which United acts as agent or claims administrator (the "Plans")) for wrongfully  
25 submitted claims previously submitted by Plaintiffs and paid by United or the Plans.

1 **NINETEETH AFFIRMATIVE DEFENSE**

2 19. Plaintiffs' alleged reliance on information allegedly provided by United during  
3 the telephone calls referenced in the Complaint was neither reasonable nor foreseeable in so  
4 far as United made clear that any payment it would provide to the Plaintiffs' was contingent  
5 on the patient's qualifying for benefits under the term of his or her health plan.

6  
7 **TWENTIETH AFFIRMATIVE DEFENSE**

8 20. Plaintiffs' claims are barred by laches/estoppel, or as a result of Plaintiffs'  
9 wrongful conduct.

10  
11 **TWENTY FIRST AFFIRMATIVE DEFENSE**

12 21. Any loss or damage that Plaintiffs allege is due to the fault or responsibility of  
13 persons and entities over whom Defendants have no control, including Plaintiffs.

14 WHEREFORE, Defendants pray for judgment as follows:

- 15 (1) That Plaintiffs' Complaint and each cause of action thereof be dismissed with  
16 prejudice;  
17 (2) That Plaintiffs take nothing by their Complaint;  
18 (3) That Defendants be awarded their costs incurred herein, including attorneys'  
19 fees; and  
20 (4) That the Court order such other and further relief for Defendants as the Court  
21 may deem just and proper.

22 Dated:

23 **WALRAVEN & WESTERFELD LLP**

24 By:   
25 **BRYAN S. WESTERFELD**

26 Attorneys for UnitedHealth Group,  
27 Inc., United Healthcare Services,  
28 Inc., United Healthcare Insurance  
Company, and OptumInsight, Inc.

**PROOF OF SERVICE**

STATE OF CALIFORNIA        }  
COUNTY OF ORANGE        } ss

I am employed in the County of Orange, State of California. I am over the age of 18 years and not a party to the within action. My business address is 101 Enterprise, Suite 350, Aliso Viejo, CA 92656.

On April 18, 2014, I served the foregoing document(s) described as

**ANSWER TO COMPLAINT**

on all interested parties in this action as follows (or as on the attached service list):


Daron L. Tooch  
Hooper & Lundy & Bookman, P.C.  
1875 Century Park East, Suite 1600  
Los Angeles, CA 90067

E-Mail:  
dtooch@health-law.com  
bwoolley@health-law.com

☒ (VIA U.S. MAIL) I served the foregoing document(s) by U.S. Mail, as follows: I placed true copies of the document(s) in a sealed envelope addressed to each interested party as shown above. I placed each such envelope with postage thereon fully prepaid, for collection and mailing at Walraven & Westerfeld LLP, Aliso Viejo, California. I am readily familiar with Walraven & Westerfeld LLP's practice for collection and processing of correspondence for mailing with the United States Postal Service. Under that practice, the correspondence would be deposited in the United States Postal Service on that same day in the ordinary course of business.

I declare under penalty of perjury under the laws of the State of California that the above is true and correct.

Executed on April 18, 2014, at Aliso Viejo, California.

  
Jessica M. Ridley

1 DARON L. TOOCH (State Bar No. 137269)  
ERIC D. CHAN (State Bar No. 253082)  
2 **HOOPER, LUNDY & BOOKMAN, P.C.**  
1875 Century Park East, Suite 1600  
3 Los Angeles, California 90067-2517  
Telephone: (310) 551-8111  
4 Facsimile: (310) 551-8181  
E-Mail: dtooch@health-law.com

5 Attorneys for Plaintiffs

7 **SUPERIOR COURT OF THE STATE OF CALIFORNIA**  
8 **COUNTY OF LOS ANGELES, CENTRAL DISTRICT**

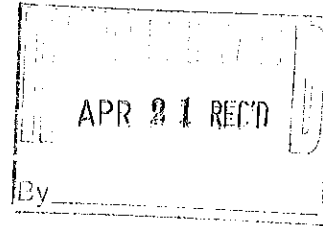
9 ALMONT AMBULATORY SURGERY  
CENTER, LLC, a California limited liability  
10 company; BAKERSFIELD SURGERY  
INSTITUTE, LLC, a California limited  
11 liability company; INDEPENDENT  
MEDICAL SERVICES, INC., a California  
12 corporation; MODERN INSTITUTE OF  
PLASTIC SURGERY & ANTIAGING, INC.,  
13 a California corporation; NEW LIFE  
SURGERY CENTER, LLC, a California  
14 limited liability company, dba BEVERLY  
HILLS SURGERY CENTER; ORANGE  
15 GROVE SURGERY CENTER, LLC, a  
California limited liability company; SAN  
16 DIEGO AMBULATORY SURGERY  
CENTER, LLC, a California limited liability  
17 company; SKIN CANCER &  
RECONSTRUCTIVE SURGERY  
18 SPECIALISTS OF BEVERLY HILLS, INC.,  
a California corporation; VALENCIA  
19 AMBULATORY SURGERY CENTER, LLC,  
a California limited liability company; WEST  
20 HILLS SURGERY CENTER, LLC, a  
California limited liability company,

21 Plaintiffs,

22 vs.

23 UNITEDHEALTH GROUP, INC.; UNITED  
24 HEALTHCARE SERVICES, INC.,  
UNITEDHEALTHCARE INSURANCE  
25 COMPANY; OPTUMINSIGHT, INC., and  
DOES 1 through 20, inclusive,

26 Defendants.  
27  
28



CASE NO. BC540056

**NOTICE OF CASE MANAGEMENT  
CONFERENCE**

Hon. Debre Katz Weintraub, Dept. 47

Complaint Filed: March 21, 2014  
Trial Date: None Set

HOOPER, LUNDY & BOOKMAN, P.C.  
1875 CENTURY PARK EAST, SUITE 1600  
LOS ANGELES, CALIFORNIA 90067-2517  
TEL: (310) 551-8111 • FAX: (310) 551-8181

1 TO ALL PARTIES AND THEIR ATTORNEYS OF RECORD:

2 PLEASE TAKE NOTICE that the court has scheduled a Case Management Conference for  
3 July 11, 2014 at 8:30 a.m. in Dept. 47 of the above-entitled court, located at 111 North Hill Street,  
4 Los Angeles, California 90012. A copy of the Court's Notice is attached hereto.

5  
6 DATED: April 17, 2014

HOOPER, LUNDY & BOOKMAN, P.C.

7  
8 By: 

9 ERIC B. CHAN

10 Attorneys for Plaintiffs  
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HOOPER, LUNDY & BOOKMAN, P.C.  
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LOS ANGELES, CALIFORNIA 90067-2517  
TEL: (310) 551-8111 • FAX: (310) 551-8181

CONFORMED COPY  
ORIGINAL FILED  
FILE STAMP Superior Court of California  
County of Los Angeles

APR -9 2014

Sherri R. Carter, Executive Officer/Clerk  
By Graciela S. Hironaka, Deputy

**SUPERIOR COURT OF CALIFORNIA, COUNTY OF LOS ANGELES**

CASE NUMBER

BC540056

**NOTICE OF CASE  
MANAGEMENT CONFERENCE**

OTICE SENT TO:  
Cooper, Lundy & Bookman, P.C.  
875 Century Park East, Suite 1600  
Los Angeles CA 90067-2517

ALMONT AMBULATORY SURGERY CENTER LLC ET  
Plaintiff(s),

VS.

UNITEDHEALTH G

Defendant(s).

**TO THE PLAINTIFF(S)/ATTORNEY(S) FOR PLAINTIFF(S) OF RECORD:**

You are ordered to serve this notice of hearing on all parties/attorneys of record forthwith, and meet and confer with all parties/attorneys of record about the matters to be discussed no later than 30 days before the Case Management Conference.

Your Case Management Conference has been scheduled for July 11, 2014 at 8:30 am in Dept. 47  
111 North Hill Street, Los Angeles, California 90012.

**NOTICE TO DEFENDANT: THE SETTING OF THE CASE MANAGEMENT CONFERENCE DOES NOT EXEMPT THE  
DEFENDANT FROM FILING A RESPONSIVE PLEADING AS REQUIRED BY LAW.**

Pursuant to California Rules of Court, rules 3.720-3.730, a completed Case Management Statement (Judicial Council form # M-110) must be filed at least **15 calendar days** prior to the Case Management Conference. The Case Management Statement may be filed jointly by all parties/attorneys of record or individually by each party/attorney of record. You must be familiar with the case and be fully prepared to participate effectively in the Case Management Conference.

At the Case Management Conference, the Court may make pretrial orders including the following, but not limited to, an order establishing a discovery schedule; an order referring the case to Alternative Dispute Resolution (ADR); an order reclassifying the case; an order setting subsequent conference and the trial date; or other orders to achieve the goals of the Trial Court Delay Reduction Act (Gov. Code, section 68600 et seq.)

Notice is hereby given that if you do not file the Case Management Statement or appear and effectively participate at the Case Management Conference, the Court may impose sanctions pursuant to LASC Local Rule 7.13, Code of Civil Procedure sections 77.5, 575.2, 583.150, 583.360 and 583.410, Government Code Section 68608 (b), and California Rules of Court 2.2 et seq.

Date: April 9, 2014

**CERTIFICATE OF SERVICE**

*Debra Katz Weintraub*  
DEBRA KATZ WEINTRAUB  
Judicial Officer

I, the below named Executive Officer/Clerk of the above-entitled court, do hereby certify that I am not a party to the cause herein, and that on this date I served the Notice of Case Management Conference upon each party or counsel named above:

☒ by depositing in the United States mail at the courthouse in Los Angeles, California, one copy of the original filed herein in a separate sealed envelope to each address as shown above with postage thereon fully prepaid.

☐ by personally giving the party notice upon filing the complaint.

Date: April 9, 2014

Sherri R. Carter, Executive Officer/Clerk

by G.S. HIRONAKA, Deputy Clerk

ACIV 132 (Rev. 09/07)  
ASC Approved 10-03

Cal. Rules of Court, rule 3.720-3.730  
LASC Local Rules, Chapter Seven

**PROOF OF SERVICE****STATE OF CALIFORNIA, COUNTY OF LOS ANGELES**

At the time of service, I was over 18 years of age and not a party to this action. I am employed in the County of Los Angeles, State of California. My business address is 1875 Century Park East, Suite 1600, Los Angeles, CA 90067-2517.

On April 17, 2014, I served true copies of the following document(s) described as **NOTICE OF CASE MANAGEMENT CONFERENCE** on the interested parties in this action as follows:

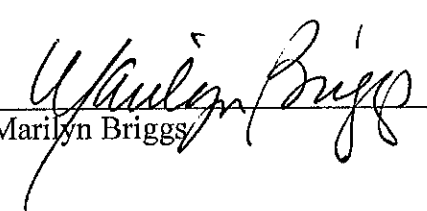
Bryan S. Westerfeld  
Walraven & Westerfeld, LLP  
101 Enterprise, Suite 250  
Aliso Viejo, California 92656  
Telephone: (949) 215-1997  
Facsimile: (949) 215-1999

Attorneys for Defendants,  
Unitedhealth Group, Inc.;  
United Healthcare Services, Inc.;  
Unitedhealthcare Insurance Company;  
and Optuminsight, Inc.

**BY MAIL:** I enclosed the document(s) in a sealed envelope or package addressed to the persons at the addresses listed in the Service List and placed the envelope for collection and mailing, following our ordinary business practices. I am readily familiar with Hooper, Lundy & Bookman, P.C.'s practice for collecting and processing correspondence for mailing. On the same day that correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the United States Postal Service, in a sealed envelope with postage fully prepaid. I am a resident or employed in the county where the mailing occurred. The envelope was placed in the mail at Los Angeles, California.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on April 17, 2014, at Los Angeles, California.

  
Marilyn Briggs

HOOPER, LUNDY & BOOKMAN, P.C.  
1875 CENTURY PARK EAST, SUITE 1600  
LOS ANGELES, CALIFORNIA 90067-2517  
TEL: (310) 551-8111 • FAX: (310) 551-8181